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TITRE/TITLE: Canada's Response to the Ashley Smith Inquest Recommendations

SOMMAIRE EXÉCUTIF/EXECUTIVE SUMMARY

- As part of your mandate letter, expectations were expressed for a review of criminal justice reforms including the implementation of the recommendations from the Ashley Smith inquest that relate to the treatment of the mentally ill and use of administrative segregation in federal institutions.
- On May 1, 2014, the Government of Canada responded publicly with the Mental Health Action Plan (MHAP), which identified deliverables in five key areas. The response of Correctional Service Canada (CSC) to the inquest recommendations was based on MHAP and is a result of the work of a steering committee made up of deputy ministers.
- CSC has implemented many changes to its health care governance and services. CSC has implemented new directives and policies governing the use of administrative segregation focusing on mental health needs; all of which has significantly enhanced CSC's responsiveness to the needs of these inmates. CSC has incorporated any outstanding items into its 2015-2016 *Report on Plans and Priorities*.
- The Department of Justice has been, and will continue to be involved in issues respecting mental health and administrative segregation in federal institutions; however, at the federal level, the bulk of these issues fall under the responsibilities of the Minister of Public Safety.

Soumis par (secteur)/Submitted by (Sector): Public Safety, Defence and Immigration

Responsable dans l'équipe du SM/Lead in the DM Team: Scott Nesbitt

Revue dans l'ULM par/Edited in the MLU by: Olivier Cullen

Soumis au CM/Submitted to MO: December 4, 2015

Protected B
FOR INFORMATION

2015-013694

MEMORANDUM FOR THE MINISTER

Canada's Response to the Ashley Smith Inquest Recommendations

ISSUE

As part of your mandate letter from the Prime Minister, you were asked to review the implementation of the recommendations from the Ashley Smith Inquest. This note provides you with background on this issue and an update of the Correctional Service of Canada's (CSC) work to date.

BACKGROUND

Ashley Smith was a 19 year-old federal offender who died of asphyxiation in federal custody on October 19, 2007. She was serving an aggregate sentence of over six years. She had been in provincial youth custody for five years prior to being transferred to the CSC. During most of her time in custody, both provincially and federally, she was placed in administrative segregation because of the need for constant supervision given her history of self-injury and risk for suicide.

A provincial coroner's inquest began January 14, 2013, and a verdict of homicide[1] was reached December 2, 2013. The jury made 104 recommendations (Annex 1) implicating a broad range of the CSC's operations as well as other federal departments, including the Auditor General of Canada and the Office of the Correctional Investigator.

The Recommendations and the Government of Canada's response

The 104 recommendations fell under six themes: 1) mental health programs and services as it relates to self-injurious behaviour, 2) offender management and correctional operations, 3) correctional programs and reintegration, 4) governance, 5) review and reporting, and 6) training.

A Deputy Ministers Steering Committee (DMSC) was tasked with studying the Recommendations as well as analyzing the effectiveness of the significant changes that had already been implemented since 2007. The DMSC was jointly chaired by the Deputy Minister of Public Safety and the CSC Commissioner. The Deputy Minister of Justice participated in this committee along with the Chairman of the Parole Board of Canada and the Deputy Minister of Health. The DMSC also engaged community stakeholders. The DMSC provided the foundation for the Government's response.

[1] A finding of homicide in the coroner's system is a finding of fact and does not carry with it a determination of guilt. It is not the same as a criminal finding of homicide. In a provincial coroner's inquest, a jury is tasked with making a finding of fact as to how a person died by choosing from the following: a) natural causes, b) suicide, c) accident, or d) homicide. In this context, a person or persons will have committed homicide if their conduct was a contributing cause to the death in more than a minimal way.

CSC's response and implementation of the Recommendations

On May 1, 2014, the former Minister of Public Safety announced the Mental Health Action Plan (MHAP). The MHAP was developed as a direct result of the Recommendations and is a comprehensive strategy to enhance CSC's mental health capacity in institutions and in the community.

In December 2014, CSC responded publicly to the Recommendations, which contained a report of actions taken to date, as well as some new action items (response attached at Annex 2). The MHAP was the foundation for the response. CSC has implemented many changes to its health care and operational systems in order to enhance its responsiveness to the needs of inmates. All relevant policies implicated in Ashley Smith's treatment have been amended. The following are examples of those changes.

1) Assessment: Implementation of CSC's Mental Health Strategy (MHS), which includes computerized mental health screening system/assessment and creation of a national psychiatric position to provide strategic advice and consultation on complex cases.
2) Management: In consultation with community stakeholders, CSC revised its directive governing administrative segregation, enhancing oversight and review mechanisms with mental health workers engaged throughout decision-making and adding a mental health assessment within the first 24 hours of admission. Those inmates on suicide watch are not put in administrative segregation.
3) Intervention: As part of the MHS, CSC created interdisciplinary teams with health professionals, and created new units and approaches to divert high needs mental health inmates to specialized units called intermediate health care sites and Structured Living Units. CSC also entered into a new partnership with the Royal Ottawa Mental Health Care Group (Brockville) to increase external options for complex mental health cases.
4) Training and development: CSC trained approximately 8,800 staff on the fundamentals of mental health care and developed new 'lessons learned ethics training,' which is currently being implemented.
5) Governance and oversight: CSC implemented governance changes to mental health services. CSC Treatment Centre Facilities are designated as psychiatric hospitals and accredited by Accreditation Canada.

CSC has implemented most of the action items identified in CSC's response and has incorporated any remaining commitments into its 2015-2016 *Report on Plans and Priorities*.

CONSIDERATIONS

s.21(1)(a)
s.21(1)(b)
s.23

[redacted]

s.21(1)(a)
s.21(1)(b)
s.23

[redacted] CSC collaborates with provincial heads of corrections as well as international state counterparts in reviewing policies and practises around administrative segregation and mental health.

CSC is currently facing legal challenges to the laws, policies, and practises regarding administrative segregation and its use for inmates with mental health issues and Indigenous people. This includes public interest constitutional challenges commenced in the superior courts as well as systemic and individual complaints before the Canadian Human Rights Tribunal. Further information on these proceedings will be provided separately.

ANNEXES

Annex 1: Ashley Smith Inquest Recommendations
Annex 2: *Response to the Coroner's Inquest Touching the Death of Ashley Smith*

PREPARED BY

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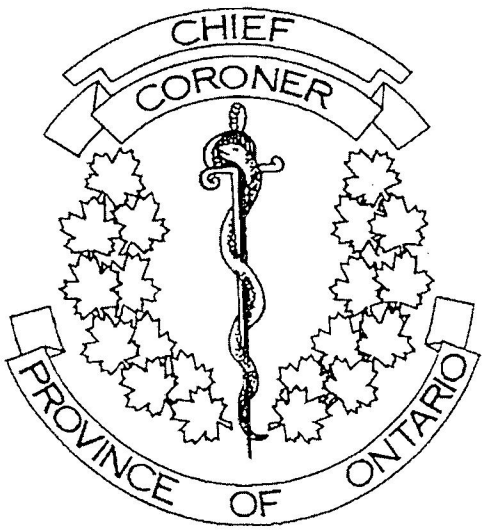

INQUEST

TOUCHING THE DEATH OF

Ashley Smith

COPY

JURY VERDICT AND RECOMMENDATIONS

FOR INFORMATION ONLY
NOT OFFICIAL
VERDICT/RECOMMENDATIONS

December 2013

Office of the Chief Coroner
Bureau du coroner en chef

COPY

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

Margaret Cruz	of / de	Toronto
Susan Tilk	of / de	Toronto
Cherish De Moura	of / de	Toronto
Kiran Chandra	of / de	Toronto
Anna D'Amato	of / de	Toronto

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
Smith	Ashley

aged / à l'âge de 19 held at / tenue à Coroner's Court Toronto, Ontario

from the / du September 20, 2012 to the / au December 19 20 2013

By / Par Dr. / Dr John Carlisle Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Ashley Smith

Date and Time of Death / Date et heure du décès
October 19, 2007 at 8:10 a.m.

Place of Death / Lieu du décès
St. Mary's General Hospital in Kitchener

Cause of Death / Cause du décès
Ligature strangulation and positional asphyxia.

By what means / Circonstances du décès
Homicide

Original signed by: Foreman / Original signé par : Président du jury

Original signed by jurors / Original signé par les jurés

FOR INFORMATION ONLY
NOT OFFICIAL
VERDICT/RECOMMENDATIONS

The verdict was received on the / Ce verdict a été reçu le 19th (Day / Jour) day of / December (Month / Mois) 20 13

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. John Carlisle	2013/12/19

Coroner's Signature / Signature du coroner

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Inquest into the death of:
Enquête sur le décès de :

Ashley Smith

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

THE ASHLEY SMITH CASE STUDY

WE RECOMMEND:

1. That Ashley Smith's experience within the correctional system is taught as a case study to all Correctional Service of Canada management and staff at the institutional, regional and national levels. This case study can demonstrate how the correctional system and federal/provincial health care can collectively fail to provide an identified mentally ill, high risk, high needs inmate with the appropriate care, treatment and support. This case study can also demonstrate the lack of communication, cohesiveness, and accountability of a large organization such as Correctional Service of Canada.

2. That the Ashley Smith case study be designed for all existing and future CSC management and staff, offering a comprehensive understanding and gaps analysis of the practices that occurred leading to this case. This case study will include documents and evidence presented throughout the Ashley Smith Coroner's Inquest, specifically:

- The Jury's Recommendations, December 2013;
- Report to Coroner Investigating the Death of Ashley Smith at Grand Valley Institution for Women (GVI), October 11, 2013, University of Toronto, Professor Kelly Hannah-Moffat (Exhibit 206);
- A Preventable Death, June 20, 2008, Correctional Investigator of Canada (pages 1-30) (Exhibit 22); and
- The Ashley Smith Report, June 2008, Ombudsman and Child and Youth Advocate (excerpts) (Exhibit 6).

THE PROVISION OF MENTAL HEALTH CARE TO FEDERALLY SENTENCED WOMEN

A. WITHIN PENITENTIARIES

WE RECOMMEND:

3. That, within 72 hours of admission to any penitentiary or treatment facility, all female inmates will be assessed by a psychologist to determine whether any mental health issues and/or self-injurious behaviours exist.

a) That, should an inmate be identified as having high needs mental health issues and/or self-injurious behaviours, the Chief of Psychology will notify the Institutional Head, Rights Advisor and Inmate Advocate (RA-IA)*, Women Offender Sector, and the Regional Complex Mental Health Committee in writing within 48 hours of assessment.

b) That this process of assessment will continue to be conducted on an on-going basis and as required by the inmate.

c) That the Chief of Psychology implements a plan of effective treatment strategy which will be documented and shared as required.

*The role of the RA-IA is defined in Recommendations #73-75.

4. That a full range of effective therapeutic interventions are:

a) individualized to the needs of female inmates considering her self-identified needs, regardless of their security classification, status, or placement;

b) enhanced to include de-escalation training, and art, music, or pet therapy;

c) trauma-, age-, and gender-informed, and developmentally appropriate; and

d) determined and authorized by mental health staff.

5. That Correctional Service of Canada (CSC) create a permanent peer support program, with highly trained and qualified peer support workers in each of the women's penitentiaries that:

(a) is available to all women, including segregated women and regardless of security status, upon their request, 24 hours a day;

(b) provides training and on-going support for the peers by women-centred psychologists and social workers;

(c) ensures confidentiality between the female inmate and the peer to the greatest extent possible;

(d) can be utilized during an incident of self-injurious behaviour, if requested; and

(e) is offered to women actively engaged in self-injurious behaviour or at risk of engaging in self-injurious behaviour as a therapeutic intervention.

6. That CSC ensure nursing services are present on-site for inmates on a 24 hour per day, 7 day per week basis, as well as available to staff for consultation.

7. That CSC access community mental health services by developing partnerships with external mental health experts.

8. That there be adequate staffing of qualified, mental health care providers with expertise and experience in treating a population with mental health issues, self-injurious behaviours, suicidality, and trauma, at every women's institution to provide services and supports to female inmates. These providers will include:

(a) Psychiatrists;

(b) Psychiatric Nurses or Nurses;

(c) The Chief Psychologist*;

(d) Psychologists;

(e) Social Workers;

(f) Behavioural Counsellors** and/or Recreational Counsellors;

(g) General Practitioners; and

(h) Other professional service providers, as required.

*It is further recommended that, whether working in the position indeterminately or in an acting capacity, the Chief Psychologist must hold a Ph.D. in Clinical Psychology and be a member in good standing of the Ontario College of Psychologists (or provincial equivalent).

**It is further recommended that behavioural counsellors have qualifications to counsel in behaviour. Otherwise, it is recommended that the title of Behavioural Counsellor is amended to Behavioural Therapy Coordinator.

9. That CSC expand the scope and terms of psychiatrists' contracts to enable them to fulfill their duties in a meaningful way.

10. That all staff providing mental health care will report to, and be accountable to, health care, not security, and that the therapeutic relationship should not be compromised by the assignment of security-focused assessments.

11. That CSC organize and fund secondments for nursing staff to psychiatric wards of local Schedule 1 hospitals, or other specialized mental health institutions. These secondments are to be of sufficient length and completed with regularity. This will ensure the continual improvement of their knowledge and skills in the provision of mental health care, services and supports to female inmates, and their knowledge of community nursing practices and standards

generally.

12. That the decision to disclose information to security by a mental health care provider should be governed by the applicable legislation, and professional and ethical standards, bearing in mind that reporting may affect the therapeutic relationship. The decision to disclose must also take into account the paramount duty of CSC to ensure the safety of the inmate. Service providers should be encouraged to consult with their professional governing bodies or colleagues when determining the necessity of disclosure.

13. That CSC create an institutional social worker position or positions whose responsibility will include working in consultation with local Canadian Association of Elizabeth Fry Societies (CAEFS), and other community groups, to identify, coordinate and access available community services, including mental health services and supports. The mandate of this position would include the dissemination of information regarding the availability of, and assistance with connecting to, such services and supports to female inmates and to staff (including contract-based clinicians).

14. That CSC be required to provide all contract physicians with copies of Commissioner's Directives, including revisions to Commissioner's Directives, that govern their practice within the penitentiary.

B. ALTERNATIVES TO PENITENTIARY

WE RECOMMEND:

15. That female inmates with serious mental health issues and/or self-injurious behaviours serve their federal terms of imprisonment in a federally-operated treatment facility, not a security-focussed, prison-like environment.

16. That female inmates who have been identified as having serious mental health issues and/or self-injurious behaviours be promptly transferred to such a facility as soon as reasonably practicable.

17. That such a facility or facilities be made available at least on a regional basis, and particularly in Ontario. It is urged that more than one federally-operated treatment facility is available for high risk, high needs women in the event that a major conflict occurs between the inmate and staff. Furthermore, and specifically, that existing male federally-operated treatment facilities be adapted to accommodate a wing for female inmates.

18. That CSC negotiate arrangements with provincial health care facilities to provide long-term treatment to female inmates who chronically engage in self-injurious behaviour or display other serious mental health problems. Further:

a) that the Government of Canada sufficiently and sustainably funds the CSC to enter into such agreements;

b) that this will include any and all capital and operating costs associated with the establishment of such facilities, and that the accommodation and treatment of female inmates therein will be the responsibility of CSC;

c) that the focus of such a facility be on the preparation for treatment of, and treatment of, the inmate; and

d) that a female inmate with mental health issues and/or self-injurious behaviour who is not consenting, and/or withdraws consent, to treatment remain in a pre-contemplative therapeutic environment for the purpose of allowing health care professionals to seek her consent to treatment.

19. That decision-making with respect to the clinical management and interventions of inmates with mental health issues are made by clinicians in consultation with the inmate, rather than by security management and staff.

20. That a treatment facility has the capacity to be designated as the home facility of a female inmate serving her sentence therein.

21. That such a facility in Ontario, or a part thereof, be designated as a Schedule 1 facility under the Ontario Mental Health Act.

22. That inmates in such facilities must have access to an independent patient advocate system, equivalent to the advocacy system to be provided to inmates in penitentiaries, pursuant to these recommendations, including the newly adopted RA-IA (see Recommendations #73-75).

MANAGEMENT OF COMPLEX HIGH NEEDS FEMALE INMATES

WE RECOMMEND:

23. That a Treatment Team is created at the institutional level to support high needs female inmates with a consistent and dedicated team of qualified health professionals, which will include psychiatrists, psychologists and

general practitioners, and that such a team:

(a) meet during the psychiatrist's regular visits at the institution in order to provide on-going, timely, and regular care to inmates;

(b) support the inmate regardless of her security classification, status, or placement within the institution;

(c) seek input from the inmate about the efficacy of her therapeutic relationships and interventions on an on-going basis;

(d) seek input from frontline staff assigned to support the inmate with mental health care needs; and

(e) develop management plans for the purposes of therapeutic intervention and preventative measures. This plan will take into account the inmate's past experiences of trauma, and the potentially traumatic effects of being incarcerated, segregated and/or restrained, and further, that such management plans are developmentally-appropriate, and age- and gender-informed.

24. That the selection of the frontline staff assigned to a female inmate will consider:

(a) the skill and interest of the frontline staff;

(b) the wishes of the inmate; and

(c) input from the Treatment Team.

25. That CSC maintain a roster of external psychologists and psychiatrists to provide a second opinion regarding treatment, services and/or recommendations when challenging behaviours are identified.

26. That an external and independent review be conducted of the Regional and National Complex Mental Health Committees to determine their efficacy, and identify opportunities for improvements.

SEGREGATION AND SECLUSION

WE RECOMMEND:

27. That, in accordance with the Recommendations of the United Nations Special Rapporteur's 2011 Interim Report on Solitary Confinement, indefinite solitary confinement should be abolished.

28. That there should be an absolute prohibition on the practice of placing female inmates in conditions of long-term segregation, clinical seclusion, isolation, or observation. Long-term should be defined as any period in excess of 15 days.

29. That until segregation and seclusion is abolished in all CSC-operated penitentiaries and treatment facilities:

a) CSC restricts the use of segregation and seclusion to fifteen (15) consecutive days, that is, no more than 360 hours, in an uninterrupted period;

b) That a mandatory period outside of segregation or seclusion of five (5) consecutive days, that is, no less than 120 consecutive hours, be in effect after any period of segregation or seclusion;

c) That an inmate may not be placed into segregation or seclusion for more than 60 days in a calendar year; and

d) That, in the event an inmate is transferred to an alternative institution or treatment facility, the calculation of consecutive days continues and does not constitute a "break" from segregation or seclusion.

30. That conditions of segregation be the least restrictive as possible for inmates and determined on a case by case basis – female inmates in segregation should, as much as possible, have access to programs, activities, and facilities and have contact with other inmates, staff, visitors, and non-governmental organizations, such as CAEFS.

31. That, as a mandatory duty, the Institutional Head will visit all inmates in segregation, seclusion, or medical observation at least once every day, in addition to meeting with individual inmates upon their request. This meeting is not to be accomplished through the food slot under any circumstance, and:

(a) that, on days when the Institutional Head is away, the visit will be conducted by the highest authority; and

(b) that any such authority must report in writing to the Institutional Head the findings and outcomes of such visits.

32. That, as a mandatory duty, a mental health professional will visit all inmates in segregation, seclusion, or medical observation at least once every day, in addition to meeting with individual inmates upon their request. This visit will pay particular attention to both the mental and physical health of such inmates, with a focus on assessing the inmate's tolerance to segregation. This meeting is not to be accomplished through the food slot under any circumstance.

33. That a sub-roster team of frontline staff is dedicated to complex high needs female inmates in the segregation unit, with a minimum of one (1) to two (2) consistent staff at all times. Such a team will ensure comprehensive and consistent support for the inmate.

34. That CSC repeal its existing Review of Offender's Segregated Status Working Day Review policies and replace them with five (5) and ten (10) day reviews that are administered by way of consecutive calendar days. This review will focus on the inmate's needs and behaviours with the goal of returning the inmate to the general population.

35. That CSC amend its current policies to ensure that female inmates held in "seclusion" or "mental health observation" are recognized as being on "segregation status" and are therefore entitled to all relevant reviews.

36. That CSC make every effort to ensure that female inmates, including those in segregation or observation cells, have access to, and the opportunity to meet in private with, the RA-IA, Office of the Correctional Investigator, Citizens Advisory Committee, non-governmental organizations and community agencies.

37. That, for the purposes of monitoring and tracking, the Institutional Head will notify the following bodies once any inmate has been placed in segregation or seclusion, and that they will also be responsible for conducting a yearly review.

(a) Women Offender Sector;

(b) Mental Health Services Branch;

(c) Office of the Correctional Investigator;

(d) RHQ – Members of the Regional Complex Mental Health Committee; and

(e) NHQ – Members of the National Complex Mental Health Committee.

RESTRAINTS (PHYSICAL AND/OR CHEMICAL)

WE RECOMMEND:

38. That, in the development of any new policy on the use of restraints, CSC move toward a restraint-free environment by implementing a least restraint policy, and that this recommendation is reflected in CD 843.

39. That the application of restraints must be authorized by a psychiatrist or psychologist, and that this recommendation is reflected in CD 843.

40. That any inmate placed in restraints is given one-on-one therapeutic support for the entire time in restraints, and that this recommendation is reflected in CD 843.

BODY CAVITY SEARCHES

WE RECOMMEND:

41. That body cavity searches for female inmates may only occur in the following circumstances:

a) with the consent of the inmate; or

b) in the absence of consent, only in exceptional circumstances. For greater clarity, exceptional circumstances will only exist when, in the opinion of a physician, there is a risk of death or serious bodily harm to the inmate or another person and the risk cannot be mitigated through any other reasonably available means.

All examinations are to be performed by a licensed medical professional at an external medical facility, in a manner most compatible with the inherent dignity of the inmate. Correctional Service of Canada staff escorting the inmate to

the external facility is to request that the examination be conducted by a female.

42. That, for the purposes of continuity of care, the institutional psychologist is notified within 24 hours of any body cavity search conducted on a female inmate, including those in treatment facilities.

SELF-INJURIOUS BEHAVIOURS

A. REPORTING OF INCIDENTS

WE RECOMMEND:

43. That all incidents of self-injurious behaviour must be reported as such.

44. That all reports regarding incidents of self-injurious behaviour, incident reports and Officer Statement Observation Reports, must contain a detailed description of the nature of the self-injurious behaviour and a detailed description of any physical injury or changes in physical well-being of the inmate.

45. That all reports regarding incidents of self-injurious behaviour must be forthwith distributed to, and read by the following:

(a) The Warden;

(b) The Chief of Healthcare;

(c) The Chief Psychologist;

(d) Women Offender Sector (for female inmates);

(e) Office of the Correctional Investigator;

(f) RHQ – Members of the Regional Complex Mental Health Committee;

(g) NHQ – Members of the National Complex Mental Health Committee; and

(h) For additional clarity, the duty to read such reports is not delegable, except in circumstances when the responsible officer is on leave, and even then, the responsible officer is to read such reports forthwith upon return to the institution.

46. That following each incident of self-injurious behaviour a Referral for Consultation Form be completed by nursing staff and a copy of the psychology assessment in relation to the incident be appended to this form and this package be forwarded to the institutional psychiatrist. The Chief of Healthcare will be responsible for ensuring this package is also provided to the institutional physician.

B. RESPONSES TO INCIDENTS

WE RECOMMEND:

47. That if frontline staff determine that immediate intervention is required to preserve life, there is no requirement that they seek authorization prior to intervening, or prior to calling 911.

48. That, when an inmate is engaged in self-injurious behaviours, health care staff are on-site, on a 24 hour per day, 7 day per week basis, to support the intervention.

49. That, when an inmate is engaged in self-injurious behaviours, the institutional psychologist are on-call, on a 24 hour per day, 7 day per week basis, for the purposes of supporting the intervention and de-escalating the incident when deemed necessary by frontline staff.

50. That CSC develop a new, separate and distinct model, from the existing Situation Management Model, to address medical emergencies and incidents of self-injurious behaviour.

51. That the Situation Management Model not be resorted to in any perceived medical emergency.

52. That, when reporting a Use of Force intervention to preserve the life of an inmate who has self-harmed, an expedited reporting system will apply. Further, all such incidents should be reviewed, within 48 hours, by:

(a) The Warden;

(b) The Chief of Healthcare;

(c) The Chief Psychologist;

(d) Women Offender Sector (for female inmates);

(e) Office of the Correctional Investigator;

(f) RHQ – Members of the Regional Complex Mental Health Committee; and

(g) NHQ – Members of the National Complex Mental Health Committee.

The review will focus on the mental health needs of the inmate, her behaviour and its lethality, as well as the response of frontline staff, including its appropriateness. It will assist and support the well-being of the inmate, in addition to the efforts of the institution and frontline staff. It will also include strategies to manage the inmate in a safe manner, and encourage staff to exercise good judgment.

53. That CSC policy state that any item used by an inmate for self-injury be classified as contraband.

54. That any inmate engaged in self-injurious behaviour must have a Management Plan in place within 24 hours of the first self-injurious incident, and that plan must address how staff is to respond to self-injurious behaviours.

RESPONSES TO MISCONDUCT BY INMATES WITH MENTAL HEALTH ISSUES

WE RECOMMEND:

55. That, to reduce institutional or criminal charges laid against an inmate, CSC adopts the methods of the St. Lawrence Valley Correctional and Treatment Centre model of care for disruptive or self-injurious behaviours symptomatic of a mental health disorder.

56. That, if a complaint is made to police in regard to alleged misconduct by an inmate with mental health issues, (occurring in the context of an incident of self-injurious behaviour), the Security Intelligence Officer will provide police with complete information. This will include the:

(a) behaviour that is alleged to amount to a criminal offence;

(b) context in which that behaviour occurred; and

(c) circumstances of the incident of self-injurious behaviour.

57. That, if a criminal charge is laid in regard to alleged misconduct by an inmate with mental health issues, (occurring in the context of an incident of self-injurious behaviour), a staff member who was not involved in the incident, and is selected with input from the inmate (preferably a member of her interdisciplinary team), will:

(a) attend any court appearances with the inmate;

(b) advise the prosecutor of his/her presence; and

(c) provide any information that is required by the court to deal appropriately with the charge.

TRANSFERS / ASSIGNMENTS OF HOME INSTITUTIONS

WE RECOMMEND:

58. That female inmates be accommodated in the region most proximate to her family and social supports. This principle is a priority for young adults and/or female inmates with mental health issues and/or self-injurious behaviours.

59. That non-emergency transfers of female inmates with mental health issues and/or self-injurious behaviours will occur only when it is aligned with the clinical needs of the inmate. Non-emergency transfers of female inmates with mental health issues and/or self-injurious behaviours will not occur for reasons related to constraints within the institution, or challenges related to the management of the inmate.

60. That subject to the above, a female inmate may be transferred to an institution or treatment facility so long as that transfer has the approval of clinicians (psychiatrist and/or psychologist) in the sending and receiving institutions. Prior to her discharge a current written plan must be in place for re-integrating the inmate to her home institution.

61. That, in the event a female inmate is transferred away from her home institution, the following measures will address the disadvantages that result from being detained in a location away from home. Such measures may include, but are not limited to:

(a) longer visits from family or support persons chosen by the inmate;

(b) increasing the inmate's access to family or support persons via telephone, videoconference, and/or web-cast, e.g. Skype or Facetime; and

(c) providing the inmate's family or support persons with appropriate access to telephone, videoconference and/or web-cast, when they are unable to visit the inmate due to financial restrictions.

62. That, in the event of a transfer, an inmate's/patient's medical file accompanies her during the transfer to ensure continuity of care.

63. That the receiving Treatment Team will connect with the sending institution's Treatment Team to share best practices, success stories, triggers, and recommendations.

64. That CSC create and implement an electronic medical database to facilitate access to medical information between sending and receiving penitentiaries and treatment facilities.

65. That no transfer occurs on a Friday or holiday given the reduced number of on-site staff at these times.

TRANSITION PROTOCOL FOR YOUNG ADULTS

WE RECOMMEND:

66. That CSC establish separate and distinct programs and services for young adults, ~~that is, 18-21 year olds~~, within adult institutions which will be geared toward their cultural and developmental needs (e.g. educational, vocational, therapeutic, as appropriate to specific needs and situations).

67. That CSC develop training to prepare staff to recognize and respond to the particular issues faced by a young adults housed in an adult institution.

68. That CSC develop a transition protocol that begins before a young adult is placed in, or transferred to, an adult institution, and which has the following features:

(a) provides clear and structured process for transition which is understood by incarcerated young adults and institutional management and staff;

(b) provides guidance on roles and responsibilities for those involved in the transition process;

(c) provides guidance on identifying needs and sharing information during the transition process; and

(d) helps build relationships between young offender and adult institution in order to support continuation of care.

CONTACT WITH FAMILY FOR YOUNG ADULTS

WE RECOMMEND:

69. That CSC facilitate, support, and document, at minimum, weekly communications by:

(a) increasing the inmate's access to family or support persons via telephone, videoconference, and/or web-cast, e.g. Skype or Facetime; and

(b) providing the inmate's family or support persons with appropriate access to telephone, videoconference and/or web-cast, when they are unable to visit the inmate due to financial restrictions.

70. That CSC streamline the approval process for visits and contact with families and support persons of young

adults. In particular, it will be conducted at a national level such that their families and support persons are not subjected to a repeated approval process at each institution.

71. That health care professionals advise young adults of the benefits of providing consent to disclose health information to their families or support persons.

72. That, at an institutional level, young adults are consulted on an on-going basis to determine if their needs for particular activities and programs are being met.

OVERSIGHT

A. INTERNAL MECHANISMS

WE RECOMMEND:

73. That CSC implement an independent RA-IA for all inmates, regardless of security classification, status, or placement. The institution will be responsible for advising all inmates of the existence of, and their right to contact, the RA-IA.

74. That the RA-IA will be responsible for providing advice, advocacy and support to the inmate with respect to various institutional issues, including:

a) Transition into institutions;

b) Transfers;

COPY

c) Security classification, status, or placement;

d) Parole and release eligibility, including escorted and unescorted absences;

e) Temporary absences;

f) Use of restraints – physical and chemical;

g) Seclusion and segregation;

h) Complaints and grievances;

i) Consent to treatment and capacity to consent;

j) Consent to medication, including available alternatives;

k) Consent to disclosure of information; and

l) Institutional and criminal charges.

75. That inmates are protected from reprisals related to contacting the RA-IA and exercising their rights.

B. EXTERNAL MECHANISMS

WE RECOMMEND:

76. That the Citizen Advisory Committee have unrestricted and unannounced access to local CSC-operated institutions at any time and be provided with the opportunity to speak with any female inmate, including those in segregation. These discussions will take place in private, out of hearing of staff.

77. That Citizen Advisory Committees are required to publish annual reports, and that CSC facilitate the publication of these reports on their website.

78. That non-governmental organizations, including CAEFS advocates, have broad access to local CSC-operated institutions at any time and be provided with the opportunity to speak with any female inmate, including those in segregation. These discussions will take place in private, out of hearing of staff.

SAFETY AND SECURITY

WE RECOMMEND:

79. That CSC improve the layout of the electronic control panel that opens pod and segregation doors to minimize human error. Specifically, do not have segregation buttons directly beside pod buttons.

ETHICS / WHISTLEBLOWER PROTECTION

WE RECOMMEND:

80. That an enhanced Code of Ethics be created that explicitly applies to all Correctional Service of Canada employees, from the Commissioner down to frontline staff, and that this enhanced Code will:

a) address preservation of life;

b) include provisions with the following language: "staff should be allowed to refuse to follow orders or directions without fear of discipline or reprisal whether they are right or wrong as long as there was an air of reality to the ethical/legal objection";

c) include a provision that affirms the right of all CSC staff members to report an order they believe to be illegal without fear of reprisal;

d) include a provision that addresses the individual accountability of all CSC staff and management, for example:

i. "Prison staff at all levels shall be personally responsible for, and assume the consequences of, their own actions, omissions or orders to subordinates"; and

e) include a provision that addresses the obligation of all CSC staff to respect and protect everyone's right to life, the obligation to ensure the full protection of the health of persons in their custody and the obligation to secure immediate medical attention whenever required.

81. That this enhanced Code of Ethics be taught in CORE and management training. Additionally, refresher courses will be conducted at the institutional level for all CSC staff, contract and otherwise.

82. That all management are responsible, and held accountable, for ensuring that this enhanced Code of Ethics is communicated to their staff.

POLICY DEVELOPMENT

WE RECOMMEND:

83. That inmates who have experienced mental health issues within correctional systems be involved in planning, research, training and policy development with respect to the provision of mental health care for female inmates.

84. That CSC repeal the section dealing with "Involuntary Admission and Treatment" in CD 803, or revise it to conform with community medical practices to ensure equivalency of care for inmates. Specifically, that CSC revise or repeal the requirements that:

a) a physician must assess a patient in-person before providing orders for involuntary medical treatment; and

b) all orders for involuntary health interventions be made in writing.

85. That CSC establish separate and distinct policies for young adults, that is, 18-21 year olds, within adult institutions which will be geared toward their cultural and developmental needs (e.g. educational, vocational, therapeutic, as appropriate to specific needs and situations).

STAFF BURNOUT

WE RECOMMEND:

86. That, upon recognizing burnout in themselves, staff are responsible for raising their concerns to management, and further, that management is responsible for acting upon these concerns and facilitating support.

87. That, to alleviate pressures and avoid staff burnout, the Institutional Head implements mandatory regularly scheduled respite intervals to frontline staff who primarily deal with complex high needs inmates.

TRAINING AND EDUCATION

WE RECOMMEND:

88. That CSC develop training to prepare staff to recognize and respond to the particular issues faced by a young adults housed in an adult penitentiary.

89. That managers and frontline staff who are designated to support high needs female inmates with mental health and/or self-injurious behaviours be offered training in the following areas:

a) fundamentals of mental health issues and self-injurious behaviours;

b) First Aid / CPR (current certifications based on community standards);

c) impacts of segregation on mental health, including that of young adults;

d) trauma-informed care (e.g. post-hostage-taking); and

e) medical distress and its intervention (delivered by an external clinician).

90. That all newly appointed Wardens and Deputy Wardens (whether the positions be on an acting or indeterminate capacity) have weekly mentoring sessions with an experienced mentor. These mentoring sessions will take place for at least one full year to provide the mentee with guidance, advice, and support throughout their first year in their newly appointed position. Ideally, the mentor is located in a region different from the mentee.

91. That CSC provide training and education to staff on restraint minimization and de-escalation techniques, and that any such training includes hearing from persons with lived experience who have directly experienced being placed in restraints.

92. That CSC provide all management and staff with essential refresher training to ensure they maintain the appropriate knowledge and skillsets to fulfill their roles and responsibilities.

AUTHORITY OF THE DEPUTY COMMISSIONER FOR WOMEN

WE RECOMMEND:

93. That the Deputy Commissioner for Women has direct line authority over all matters relating to female inmates. This gives clear authority and accountability to a single body that provides specialized correctional services to female inmates.

94. That the female inmates' institutions be grouped under a reporting structure independent of the Regions.

95. That, in the formation of this new reporting structure, careful consideration is given to the assignment of new positions specifically so that current employee's qualifications, skill sets and competencies are considered for best fit into the newly formed positions.

RESEARCH AND KNOWLEDGE TRANSFER

WE RECOMMEND:

96. That CSC foster working relationships with qualified mental health professionals from academic health sciences organizations (e.g. Centre for Addiction and Mental Health) and research universities. These partnerships will focus on developing treatment strategies and therapeutic practices, as supported by current literature of evidence of effectiveness, specifically for women with mental health illnesses including those engaging in self-injurious behaviour and those in segregation.

97. That CSC revitalize and continue with the research on the emergence of the third group of women who do not respond to psychotherapy or dialectical behavioural therapy.

98. That CSC implement communication structures between units conducting research at National Headquarters (e.g. Research Unit and Women Offender Sector) and local institutions to effectively disseminate information to staff through regular institutional visits. Research staff will share relevant literature on effective therapeutic interventions

with health care, mental health staff and senior management.

99. That CSC implement ongoing, internal communication structures between frontline, mental health, and health care staff as well as senior management, to effectively disseminate information. Health care and mental health staff will allocate time to meet and discuss relevant literature, complex cases and effective therapeutic interventions with frontline staff and senior management.

ACCOUNTABILITY

WE RECOMMEND:

100. That an independent, external audit be contracted by the Minister of Public Safety of CSC's compliance with this jury's recommendations. This audit will be conducted in consultation with the Office of the Correctional Investigator, and the results of such audit will be released publicly during the 2016-2017 and 2023-2024 fiscal years.

101. That the Auditor General of Canada conduct a comprehensive audit of the jury's recommendations and that the results of such audit be released publicly in 2019-2020.

VERDICT AND RECOMMENDATIONS

WE RECOMMEND:

102. That this jury's verdict and recommendations regarding the Inquest into the Death of Ashley Smith is posted in writing in every institution and treatment facility operated by the Correctional Service of Canada, in a place accessible to all staff, within thirty (30) days of the receipt of the verdict and recommendations.

103. That an electronic copy of this jury's verdicts and recommendations is made available for the public on the CSC website, for staff's reference on the CSC intranet, and that staff are immediately made aware by management.

104. That the Office of the Correctional Investigator monitor and report publicly, and in writing, on the implementation of the recommendations made by this jury annually for the next 10 years.

Personal information contained on this form is collected under the authority of the *Coroners Act*, R.S.O. 1990, C. C.37, as amended. Questions about this collection should be directed to the Chief Coroner, 26 Grenville St., Toronto ON M7A 2G9, Tel.: 416 314-4000 or Toll Free: 1 877 991-9959.

Les renseignements personnels contenus dans cette formule sont recueillis en vertu de la *Loi sur les coroners*, L.R.O. 1990, chap. C.37, telle que modifiée. Si vous avez des questions sur la collecte de ces renseignements, veuillez les adresser au coroner en chef, 26, rue Grenville, Toronto ON M7A 2G9, tél. : 416 314-4000 ou, sans frais : 1 877 991-9959.

Response to the Coroner's Inquest Touching the Death of Ashley Smith

Ottawa December 2014

Acknowledgements

Several representatives assisted to guide the study and assessment of the Coroner's Jury recommendations and the development of the Response to the Coroner's Inquest Touching the Death of Ashley Smith.

Deputy Minister Steering Committee Responding to the Recommendations from the Coroner's Inquest into the Death of Ashley Smith in Federal Custody

Co-Chairs:

Deputy Minister, Public Safety Canada
Commissioner, Correctional Service of Canada

Members:

Chairperson, Parole Board of Canada
Deputy Minister, Health Canada
Deputy Minister and Deputy Attorney General, Justice Canada

Assistant Deputy Minister Working Group Responding to the Recommendations from the Coroner's Inquest into the Death of Ashley Smith in Federal Custody

Co-Chairs:

Assistant Deputy Minister, Public Safety Canada
Regional Deputy Commissioner (Prairies), Correctional Service of Canada

Members:

Executive Director General, Parole Board of Canada
Assistant Deputy Minister, Health Canada
Senior Assistant Deputy Minister, Justice Canada

Additional consultation took place with the following representative bodies:

Federal-Provincial-Territorial Heads of Corrections

Forum with Criminal Justice and Mental Health Stakeholders on Reintegration Planning for Offenders with Mental Health Needs

October 7, 2014

TABLE OF CONTENTS

1. Introduction

Ashley Smith's death while in federal custody is an absolute tragedy that has had a profound impact on Canadians, including those that work in the criminal justice system throughout the country. Her death has brought to light many of the profound gaps in correctional systems in dealing with individuals who have mental health problems and the need to find viable alternatives that provide clinical responses to the needs of such individuals. While some changes have been implemented since 2007, and others are being pursued, there is still more work to be done to avoid such tragic incidents in the future.

On October 19, 2007, at the age of 19, Ashley Smith died while serving a federal penitentiary sentence after being found in physical distress in her cell in administrative segregation at Grand Valley Institution, a Correctional Service of Canada (CSC) facility for women. Prior to her death, there had been a lengthy series of incidents involving self-strangulation using ligatures she had made and hidden on her body, however, the lack of a consistent and comprehensive response to her behaviour contributed to her death.

Whenever an inmate dies in custody in Ontario, a Coroner's Inquest is mandatory. The Coroner's Inquest Touching the Death of Ashley Smith was convened at the Coroner's Court in Toronto, Ontario, and testimony began on January 17, 2013. The Coroner's Jury heard evidence and testimony over several months, and returned with their verdict on December 19, 2013, making 104 recommendations.

The jury classified Ashley Smith's death as a homicide. They identified ligature strangulation and positional asphyxiation as the cause of her death. This determination does not imply criminal responsibility. Rather, it means that through acts or omissions, a person or persons has or have contributed to an individual's death.

The Government of Canada immediately began a thorough review of the jury recommendations. This included an analysis of the actions CSC had already undertaken as well as those that would be required to address the intent of the jury recommendations.

Most of the jury recommendations look at the issue of the mental health of offenders in the federal corrections system, particularly among women offenders.

The issue of mental illness in Canada is significant and has become a major societal issue affecting all Canadians. It is estimated that 20% of Canadians will experience difficulties with their own mental health at some point in life. More than 70% of adults living with mental illness have reported that the onset of their difficulties occurred before they were 18 years of age.

Self-injury and suicide are among the most serious consequences of mental illness. In Canada, suicide is the leading cause of death for people between the ages of 10 and 24 years.

Although the jury determined that Ashley Smith did not commit suicide, her self-injurious behaviour clearly pointed out the gaps in the response to such behaviour in a correctional environment. The need to find a clinical response to such behaviours must be paramount.

Across Canada, provincial and territorial health care systems are burdened by an increasing demand for mental health care. As a result, agencies like CSC have slowly emerged as a last resort for people with active mental health issues who have come into conflict with the law and received a term of imprisonment.

The foundation for the response to the Coroner's Inquest Touching the Death of Ashley Smith lies in the Mental Health Action Plan for Federal Offenders, as announced by the Honourable Steven Blaney, Minister of Public Safety and Emergency Preparedness on May 1, 2014. The plan focuses on five areas (or "pillars") for action:

- Timely Assessment
- Effective Management
- Sound Intervention
- Ongoing Training and Development
- Robust Governance and Oversight

The Government and CSC recognize and commend the members of Coroner's jury for the extensive work and effort that they put into formulating the recommendations. The 104 recommendations covered a wide variety of issues and required significant review in order to construct a meaningful response that could assist in efforts to avoid deaths in custody in the future. In this response to the Coroner's inquest Touching the Death of Ashley Smith, the recommendations and associated CSC actions are organized in relation to the five pillars that the Minister of Public Safety and Emergency Preparedness announced in May 2014. The themes of the response to the recommendations allow for a more comprehensive and all encompassing reply to the intertwining and complex issues that the jury members addressed in their deliberations. These themes will also allow CSC to focus on the key elements of the larger issue of mental health within a correctional environment and to better communicate with staff, offenders, stakeholders and Canadians at large about the opportunities and challenges in dealing with this issue.

2. Timely Assessment

2.1 Jury Recommendations (3, 7, 9, 25, 46, 64, 68, 72, 84)

2.2 Background

The responsibility for Canada's health care system is shared by federal, provincial and territorial governments. Provinces and territories are directly responsible for the management and delivery of their health services, including for their provincial-territorial correctional jurisdictions. However, offenders serving sentences in federal penitentiaries are excluded from these provisions. CSC is therefore required by law, to provide essential health care, including medical, dental and mental health care, and reasonable access to non-essential care that will contribute to the inmate's rehabilitation and successful reintegration to the community (Correctional and Conditional Release Act [CCRA], 1992. C.20, s.86)

Mental Health services delivered in CSC must meet professionally accepted standards. The mental health professionals who provide those services, whether employed by CSC or under contract, must adhere to the ethical and performance standards of their Colleges or Associations in their respective province or territory. These requirements fall outside of CSC's authority.

Beginning in the late 1960s, the provinces started to reduce a reliance on inpatient mental health care in favor of a less costly and more decentralized approach to improving the effectiveness of services delivered in the community and help minimize institutionalization. This trend continued and expanded over the next two decades. As health costs escalated, provincial and territorial health systems could not keep up with the growing demand for mental health services.

The number of offenders admitted to our federal penitentiaries with a mental disorder – often undiagnosed and frequently complicated by a concurrent problem such as substance abuse, has increased since that time. The fact that people with mental disorders have the right to refuse treatment has made this situation even more complex and difficult to manage.

CSC statistics show that 13% of male offenders and 29% of women offenders admitted to federal custody have self-identified as having a mental health problem. Research suggests that of women offenders who self-injure, 93% exhibited this behaviour prior to coming to CSC.

Ashley Smith had a history of self injury and volatile behaviour before her admission from the New Brunswick correctional system to federal custody at Nova Institution in Truro, Nova Scotia on October 31, 2006.

Despite the numerous efforts made to facilitate a full mental health assessment and treatment strategy, a clear and unimpeded treatment plan failed to materialize during her eleven months of federal custody,

The Coroner's Jury was concerned about the timeliness and quality of CSC's mental health assessments and treatment planning. They recommended systemic improvements and called for the early involvement of psychologists and external specialists to ensure the continued identification and comprehensive assessment and treatment of mental health issues, including self-injurious behaviour. They urged CSC to expand its partnerships with community mental health professionals and teaching hospitals for treating offenders. The jury also emphasized the need for CSC to improve internal communication at local, regional and national levels to ensure senior officials are aware of cases similar to that of Ashley Smith.

The Government of Canada believes that safe, gradual and successful community reintegration for offenders begins on day one of any sentence. As part of its orientation process when an offender arrives at a federal institution, CSC has in place an established program to share with offenders the necessary information and expectations to facilitate a smooth transition and help them adapt to the correctional environment.

The first step in understanding each offender's specific needs begins with an individualized assessment. This includes an intake assessment which assesses and prioritizes risk factors. It also includes mental health screening to identify signs and symptoms associated with mental illness. An important part of the intake assessment process includes the collection of all relevant and available information about the offender's personal history, including the offender's physical and mental health, and social, economic, criminal and young-offender history, to assist in the assessment process.

Following these comprehensive assessments, CSC is able to develop an individualized Correctional Plan in collaboration with each offender that meets the risk and health needs of each person, male or female, younger or older, to guide the development of programs and an intervention strategy, including any mental health treatment that may be required during an offender's sentence.

2.3 Actions

Since Ashley Smith's tragic death in custody in 2007, CSC has developed a comprehensive strategy to enhance its capacity to assess and respond to the mental health needs of offenders in institutions and in the community. The aim is to strengthen the continuum of care and continuity of specialized mental health assessment and support as required throughout the duration of an offender's sentence.

Screening

Mental health screening at intake for men and women offenders is a key component of CSC's Mental Health Strategy.

When an offender is admitted to a CSC institution, an immediate needs identification interview takes place within 24 hours by a correctional staff member before cell assignment and includes a screening for suicide risk. CSC policy also requires that every offender undergo an Intake Health Status Assessment by a Registered Nurse within 24 hours of arrival which must, at a minimum, screen for communicable health conditions, acute medical or dental conditions, identify any conditions requiring continuing treatment, any activity limitations, and the initial identification of any mental health issues. The offender is then referred to the appropriate health care professional as necessary. However, in the case of a crisis situation, referral is immediate.

In addition, CSC implemented a Mental Health Screening System in January 2010 which is administered to offenders who give consent, between 72 hours and 14 days of admission, on a priority basis, beginning with high needs offenders. It is an automated screening system that provides information on an inmate's mental health status. It is purposely designed to identify offenders who may have mental health needs and who require mental health services. The process consists of four standardized psychological tests and nine mental health indicators. This screening provides early identification of offenders who are exhibiting signs or symptoms that may be associated with a mental health disorder in order to facilitate follow-up assessment and intervention. The overall collection of accurate mental health data can be used as a baseline for the longer-term planning of CSC mental health care.

An offender's results are summarized in the *Offender Summary Report*. On the basis of analysis following the collection of test scores, a referral is made regarding the need for further assessment. Any offender for whom there are significant mental health concerns that warrant further mental health assessment and/or treatment, is referred to the Psychology Unit.

Assessment

Mental Health Assessments are conducted over the course of the offender's sentence as needed. Assessments may address any or all of the following: the diagnosis of a mental disorder; cognitive functioning; the offender's ability to adapt in the institution and/or integrate successfully in the community; risk factors for criminal behaviour; or other relevant issues that may be connected to decision points during the sentence, such as transfer or release considerations.

Mental Health Assessments are normally completed no later than 30 working days after the initial interview. A mental health professional may need as many as three interviews with an offender, depending on what is necessary to prepare an expanded assessment and/or treatment plan. The length and scope of the assessment will depend on the offender's needs, the specifics of the case, and previous mental health assessments on file. An assessment is considered "up-to-date" if it continues to be an accurate reflection of the offender's mental health status, needs, and circumstances such as any significant change in the case. An updated assessment will typically provide a brief overview of the relevant historical information and a review of issues and concerns that have arisen since the most recent full assessment.

In general, a Mental Health Assessment includes the following:

- a review of relevant file information
- interview with the offender
- consultation with case management, health care and other institutional resources as necessary
- analysis of the presenting mental health issue

- an assessment of offender needs and identification of priority needs and required interventions as mutually agreed upon by the clinician and the offender
- identification of any relevant responsivity considerations
- frequency of sessions and anticipated time frames for completion of intervention
- referrals to associated interdisciplinary interventions

Since 2007, CSC has also had a dedicated fund for the provision of specialized external mental health assessments by community mental health experts.

Planning

Since Ashley Smith's death, CSC has implemented new procedures to improve the response to offenders with complex mental health care needs and difficult-to-manage behaviours. There is a two-tiered process for intervening with inmates who self-injure:

- **Short-term response** - a Critical Response and Incident Management Plan (CRIMP), which concentrates on the immediate intervention needs for an inmate following a self-injurious incident; and,
- **Long-term response** - an Interdisciplinary Management Plan (IMP). which integrates clinical, case management and security intervention plans. This tool helps staff effectively manage inmates with complex needs who self-injure repetitively, and whose ongoing behaviour poses significant challenges to the institution.

The CRIMP is completed by a mental health professional within 24 hours of each incident of self-injury. If the case specifics indicate the need for an IMP, a Comprehensive Psychological Assessment (CPA) is completed as part of the mandatory assessment for all inmates who require an IMP. A comprehensive assessment is essential for understanding the inmate and formulating appropriate clinical care. CSC Regional Treatment Centres have the option of completing a Comprehensive Psychiatric Assessment in place of the CPA.

These and other measures are detailed in the revised Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour, which came into effect in July 2011.

Review and Monitoring

In April 2010, CSC established Regional Suicide Self-Injury Prevention Management Committees (RSPMCs). These committees assist institutions to manage self-injurious and suicidal behaviour among inmates. In October 2013, CSC's Executive Committee (EXCOM) decided to expand the scope of these committees to include offenders with complex mental health needs as well as offenders who persistently and chronically self-injure. Now known as the Regional Complex Mental Health Committees (RCMHCs), they are co-chaired by the Regional Director, Health Services and the Assistant Deputy Commissioner Correctional Operations in each of the five regions. The RCMHC is comprised of both operational and mental health staff. Offenders with complex mental health needs are identified and referred by Institutional Mental Health (IMH) to a RCMHC.

The RCMHC meets monthly to review all complex cases and incidents of self-injury, focusing on repeat self-injurious behaviour, flagging items of concern, and consulting/engaging institutions to offer support and advice in the management and treatment of offenders with complex mental health needs.

For identified complex cases, CSC's Senior Psychiatrist, who is a permanent member of each RCMHC, prepares a consultation report in collaboration with Institutional Mental Health. The report includes a summary of the case history, a case formulation and recommendations moving forward.

The National Complex Mental Health Committee (NCMHC) was formed to provide support to the RCMHCs' and act as a mechanism to assist and support regions in providing an effective continuum of care to offenders experiencing significant mental health concerns who pose major challenges to sites regarding effective management and treatment. NCMHC is chaired by the Director General, Mental Health and meets monthly - or more often if necessary, to review cases of a high risk/high need nature and ensure the monitoring of incidents of suicidal and self-injurious behaviour. Membership includes the Assistant Commissioner of Health Services, Senior Psychiatrist NHQ, Regional Directors of Health Services, the Deputy Commissioner for Women (DCW) and the Assistant Commissioner, Correctional Operations and Programs (ACCOP).

CSC is currently in the process of convening an external roster of psychiatrists and psychologists to review the case formulation and treatment plans for CSC's most high risk/high needs mental health offenders (men and women) as well as to provide second opinion regarding treatment services and/or recommendations when particularly challenging behaviours are identified. Members of the roster will work directly with the RCMHCs' regarding treatment strategies for high risk/high needs offenders and will work with the NCMHC to review systemic mental health issues within CSC.

Partnership for Change

In November 2008, the Heads of Corrections (HOC) - the senior officials responsible for adult corrections from Canada's Federal/Provincial/Territorial correctional jurisdictions, created the Federal/Provincial/Territorial (FPT) Working Group on Mental

Health (WGMH). This group was tasked to develop a nation-wide corrections mental health strategy in consultation with the Mental Health Commission of Canada (MHCC).

Following extensive consultations across Canada by the FPT Working Group and MHCC, the Mental Health Strategy for Corrections in Canada was published in the Fall of 2012. This was the first national strategy of its kind. It facilitates enhanced continuum of care and services for offenders with mental health disorders and contains a section on the screening for suicide and self-injury.

Under this strategy, time spent by inmates with mental health problems and/or illnesses in the criminal justice system, is viewed as an opportunity to develop and implement new or already-established treatment plans, and to integrate the services received in correctional settings with community-based treatment and follow-up services. Valuable partnerships have been achieved through this national initiative.

This work has helped to directly inform the Mental Health Action Plan for Federal Offenders that is the foundation for the Government response to the Coroner's Inquest Touching the Death of Ashley Smith, as well as the continued evolution of CSC's Mental Health Strategy and the Government's actions moving forward with respect to mental health in the federal correction environment.

Performance

Since 2007, CSC has made a large number of mental health related commitments to address recommendations from various reports, reviews, inquests and investigations.

CSC's Internal Audit Sector is in the process of completing a review of forty mental health commitments made by CSC.

Preliminary findings would indicate that all but one were completed and that the majority have been fully or partially implemented, with a number remaining as a work in progress in terms of CSC's plans and priorities moving forward. The report is due to be published in 2015.

Improved capacity to address the mental health needs of offenders is a corporate priority for CSC. An internal review of CSC's performance in the area of Mental Health Screening at Intake during fiscal year 2013-2014 (April 1, 2013 to March 31, 2014) demonstrates that 96.3% of all offenders (4810 offenders) admitted during that period were screened by the Immediate Needs Checklist - Suicide Risk, and that 90% of newly admitted offenders (3922 offenders) were screened through use of CSC's Mental Health Screening System.

These screening and assessment measures help CSC to fulfill its statutory obligations and demonstrate the systemic improvements and qualitative progress that have been made in this area since Ashley Smith's death in 2007.

3. Effective Management

3.1 Jury Recommendations (12, 23, 27-35, 38, 39, 40, 41, 42, 46, 47, 50, 51, 53-63, 65, 69, 70, 71, 86, 87)

3.2 Background

Case Management and Institutional Supervision within CSC primarily consists of the monitoring, intervention, assessment, supervision and documentation of inmates' progress during their sentence as measured against the objectives of their individually developed Correctional Plan.

On a typical day CSC is responsible for over 22,000 offenders, including more than 15,000 inmates accommodated at federal penitentiaries across Canada.

Women represent about 5% of the total federal population or approximately 1,100 offenders, an increase of almost 8% since 2007, with approximately 600 in custody at CSC's women's institutions.

Common characteristics shared by women offenders include low self-esteem, dependency, low levels of educational and vocational achievement, parental death at an early age, frequent foster care placements, residential placement, and living on the street, participation in the sex trade, as well as suicide attempts and self-injurious behaviours. The average age of federally sentenced women offenders is 37 years old. The highest rates of criminal offending for women occur when they are 15 years old, with a steep decline reported thereafter.

Ashley Smith had been to court many times by the time she was 15 years of age. Her experience with the youth protection system in New Brunswick was a difficult one. Her disruptive behaviour resulted in formal application by youth authorities for admission to the adult system and she was eventually placed in provincial custody, spending most of her time in segregation. Issues persisted and she received a federal sentence. After she was admitted to Nova Institution her behavior continued to be a challenge to manage. Several transfers followed across four of CSC's regions over eleven months before her death at Grand Valley Institution for Women.

The use of administrative segregation, especially for women offenders and those with mental health issues, is an area of offender management that has raised significant issues.

It is a generally held belief that long term segregation produces adverse effects and worsens overall mental health and psychological functioning. Although research on the subject is not conclusive, the Government accepts that long periods in administrative segregation is generally not conducive to healthy living or meeting the goals of the correctional planning process.

CSC believes that administrative segregation should only be used when there are no reasonable alternatives and for the shortest period of time that is necessary, in accordance with a fair, reasonable and transparent decision-making process that is based on a review of all the relevant information. Based on a review in 2011-2012, the majority (82%) of admissions for women offenders into administrative segregation lasted no more than 10 days. For those remaining in segregation, CSC continued to explore viable, safe alternatives.

The circumstances that led to Ashley Smith's death raised important questions about mental health and the use of administrative segregation in the federal correctional environment.

The Jury recommendations on this issue urged CSC to reduce its use of segregation, improve administration and oversight of the segregation process, and minimize the use of restraints to control self-injurious behaviour in favor of better therapeutic practices.

The Coroner's Jury also recommended that "indefinite solitary confinement" be abolished and that long term segregation not exceed 15 days. They also wanted to see restrictions placed on the number of periods that offenders can spend segregated, including a requirement of no more than a cumulative total of 60 days in a calendar year.

To be clear, the term solitary confinement is not accurate or applicable within the Canadian federal correctional system. Canadian law and correctional policy allows for the use of administrative segregation for the shortest period of time necessary, in limited circumstances, and only when there are no reasonable, safe alternatives.

Administrative Segregation in the federal corrections system is not intended to be a form of punishment. It is an interim population management measure resulting from a carefully considered decision made by the Institutional Head to facilitate an investigation or to protect the safety and security of individuals and or the institution.

The purpose of administrative segregation is to maintain the security of the penitentiary or of any persons by not allowing an inmate to associate with other inmates when he or she meets the legislative requirements outlined in the CCRA (CCRA, 1992. C.31. s.3). These requirements emphasize that an inmate is to be released from administrative segregation at the earliest appropriate time.

Segregated inmates are entitled to all the rights and privileges of other inmates within the physical limitations of the segregation unit. There is frequent interaction with others, including staff and visitors, as well as structured contact with peers. Members of the institutional Citizens Advisory Committees also have access to all offenders in the segregation unit. Inmates are routinely provided with their personal effects, which can include books, television, hobby materials and other personal items.

Every inmate's confinement in administrative segregation is guided by regularly scheduled reviews that must conform to strict time frames (including reviews after 24 hours, 5 days, 30 days, etc.), rules for the sharing of information, the safeguarding of rights, and avenues for filing complaints and grievances as well as the right to contact legal counsel. The legislation and policy surrounding segregation is very rigorous. Decision-makers are held to the highest standards of accountability.

For these reasons, there are various aspects of the Jury recommendations in the section entitled Segregation and Seclusion (Recommendations 27 through 37) that the Government is unable to fully support without causing undue risk to the safe management of the federal correctional system. For other elements of these and related recommendations, CSC has implemented a variety of improvements that will continue to evolve going forward, especially the review, oversight and support mechanisms for segregated offenders and those engaging in self-injurious behaviour. However, CSC will continue to explore other alternatives to the use of segregation.

3.3 Actions

Since Ashley Smith's death in 2007, CSC has made significant changes to its policies and practices surrounding the use of administrative segregation.

Segregation Practices

Several key changes are linked to the Jury recommendations and can be found in Commissioner's Directive 709: Administrative Segregation, which was last revised March 10, 2014 and includes the following requirements:

- Consultation with the Case Management Team, including the parole officer, health care professionals, Elder, chaplain, or other relevant staff, prior to placement in administrative segregation during regular business hours, to ensure that alternatives have been fully explored and used where practicable,
- Completion of an Immediate Needs Checklist - Suicide Risk upon admission to administrative segregation or when the reasons for placement in administrative segregation have changed,
- More focused consideration of an inmate's mental and physical health as well as overall health care needs when making segregation decisions,

- An increased level of authority requiring the Deputy Warden to chair the Institutional Segregation Review Board at the 60-day review and subsequent reviews,
- That an inmate placed on a segregation range for the express purpose of suicide/self-injury observation (due solely to the physical location of an observation cell on the segregation range) not be officially admitted to administrative segregation under the CCRA, 1992. C.31 but clinically managed in accordance with Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour,
- That an inmate admitted to segregation but subsequently requiring suicide/self-injury observation be managed in accordance with Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour and Commissioner's Directive 709: Administrative Segregation to ensure an enhanced level of clinical oversight and to distinguish that administrative segregation placement is not a result of self injurious behaviours,
- That an inmate readmitted to administrative segregation following release for reasons such as court, outside hospital, temporary absence, or transfer, even if it is for a period exceeding 24 hours, and is returned to segregation for the same reason as before, will be considered as a continuation of segregation placement. This ensures that Regional Segregation Reviews are conducted based on the total accumulated days in segregation,
- A daily visit to the segregation unit by the Institutional Head this can no longer be delegated, and that the Institutional Head must meet with inmates in administrative segregation upon their request,
- Formalization of the National Long-Term Segregation Review Committee (NLTSRC) which is comprised of senior managers at the regional and national levels, from both operations and mental health.

In addition to the official records created in the Offender Management System (OMS), specific logs with pertinent information must be maintained in the administrative segregation unit as a whole, and for each inmate held there. An official who visits the segregation unit, including the Institutional Head, is expected to document any relevant observations and interactions and to review these logs upon visiting the unit.

Following an inmate's placement in administrative segregation, a parole officer must meet with the inmate within two working days to explore his or her reintegration options. If the inmate remains in administrative segregation after the required fifth-working day review, the parole officer, in consultation with other case management team members, including the assigned correctional officer or primary worker, must develop a Reintegration Action Plan consistent with the inmate's individual Correctional Plan that will remain focused on measures to help facilitate release from segregation.

An inmate placed in administrative segregation must, at the time of admission or without delay, be visited by a registered nurse to establish whether there are any health concerns resulting from placement or any concerns for suicide risk or self-injury. A registered nurse must visit with each inmate in administrative segregation every day.

Health services professionals, including physicians, registered nurses, psychologists or psychiatrists, must advise the Institutional Head in writing if they recommend the termination of administrative segregation, or any changes to the administrative segregation conditions, based on issues connected with the inmate's physical or mental health.

Segregation Review

When an inmate is placed in administrative segregation during regular business hours, with the exception of emergency situations, a consultation will occur with the members of the Case Management Team prior to the placement to ensure that all options other than placement in administrative segregation have been explored and utilized if appropriate. Consultation will normally include the parole officer and health care professionals and may also include the Elder, chaplain, or other relevant staff as necessary.

The Immediate Needs Checklist – Suicide Risk is completed, upon admission to administrative segregation or when the reasons for placement in administrative segregation are changed.

In the event of placement in administrative segregation outside of normal working hours, the Institutional Head will review the placement decision within one working day of the placement to either confirm the placement or order the release of the inmate from administrative segregation.

The Institutional Segregation Review Board will conduct a hearing within five working days of an inmate's placement in administrative segregation, or following any readmission, and again within 30 calendar days of the inmate's admission. Subsequent hearings are held at least once every 30 calendar days from the date of the previous 30-day review.

Within the first 25 days of an inmate's initial placement in administrative segregation and at least once every 60 days thereafter - or before if necessary, a psychologist will provide a written psychological assessment of the inmate's current mental health status, with a special emphasis on the risk for self-injury. This is shared with the Institutional Segregation Review Board to assist with the decision-making process. Copies are also provided to the inmate and placed on file.

Prior to any Institutional Segregation Review Board, the parole officer will consult with the health care professionals assigned to the case to obtain information on any health issues that may impact the inmate's segregation status, and how any health needs can be accommodated. This information will be provided to the Segregation Review Board to be considered and documented in their recommendation concerning release from administrative segregation.

A Regional Segregation Oversight Manager (RSOM) is also designated by the Deputy Commissioner in each region. The RSOM acts as a third party to provide objective oversight and monitor for compliance with segregation policies. RSOM's conduct a review of each segregation case at least once within the first 60 days of admission to ensure that all policy requirements are met and to determine if placement in administrative segregation is still justified. Each inmate is provided with a written record of this review within five working days.

A Regional Segregation Review Board (RSRB) is held to review the case of every inmate who has reached 120 days in administrative segregation. The Board will also review any case specifically referred by the RSOM to determine if continued segregation is required. The region's Assistant Deputy Commissioner of Correctional Operations chairs the RSRB and can direct the Institutional Head to take recommended action to resolve an inmate's segregation status. If required, the RSRB will hold another review at least once every 60 days after the 120-day review. The timeframe between the initial 60-day review, the 120-day review and every subsequent review will not exceed 60 days.

CSC's National Headquarters (NHQ) reviews the results of annual regional administrative segregation audits and analyzes overall trends. Regional action plans are monitored and followed up by RSOM's. Further, Segregation is an activity in the Compliance and Operational Risk Report (CORR) process whereby self-audits are conducted by all sites and results reported to EXCOM.

As part of CSC's National Population Management Strategy, the National Long-Term Segregation Review Committee (NLTSRC) was established in 2009 to provide advice on resolutions to long-term segregation cases. The NLTSRC is chaired by a senior executive from the Correctional Operations and Programs Sector and meets at a minimum on a quarterly basis to review the case status and release planning of inmates who have been segregated for 180 days and more, as well as offenders with significant mental health needs that have been in segregation for 120 days and more. The focus is on developing alternatives and strategies to reduce the number of long-term segregation cases by facilitating release from administrative segregation at the earliest appropriate time.

Key Segregation Initiatives

An Independent External Review Board on the Operational Examination of Long-Term Segregation and Segregation Placement of Inmates with Mental Health Concerns was convened in 2010 and made several recommendations on how CSC could improve its management of administrative segregation. CSC has since undertaken an initiative to identify newly admitted offenders who may be at risk of becoming segregated early in their sentence. A screening tool called the Risk of Administrative Segregation Tool is in the final stages of being developed by the Research Branch. The tool could assist in identifying offenders who would be the most likely to benefit from efforts to divert them from being placed in segregation.

In addition, a Segregation Intervention Strategy was implemented by CSC in 2011 at several men's institutions to encourage and support segregated inmates to change problematic behaviour so they can safely return to the institutional population. A research project is being conducted to determine the effectiveness of the strategy and to assess the potential benefits of expanding it to other sites.

Furthermore, CSC is developing a Segregation Renewal Strategy in order to reduce the number and length of segregation placements, prevent unwarranted admissions, and to motivate offenders for release from segregation when risk can no longer be substantiated. This strategy is intended to reframe the thinking about how segregation is used in CSC and strengthen oversight and decision-making. The goal of the strategy is to reduce the reliance on segregation by creating better options and finding more innovative alternatives for safe reintegration. Research is being planned to complement the strategy and further investigate areas of concern such as the effects of long-term segregation.

Notwithstanding the above, given the ongoing importance of this issue, CSC will further consult with external experts and other jurisdictions internationally, to develop options that will be presented to the Minister of Public Safety and Emergency Preparedness by June 2015.

Segregation Law and Policy

Legislation and policies provide procedural safeguards to ensure that administrative segregation is a fair and humane process that follows the Canadian Charter of Rights and Freedoms, particularly Section 7 (*Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice which focuses on procedural fairness*) and the duty to act fairly. Legal requirements for the use of administrative segregation are contained in the CCRA, the *Corrections and Conditional Release Regulations* (CCRR), and outlined in policy through Commissioner's Directives.

Once an inmate is placed in administrative segregation, staff must balance the risk connected to the inmate's release from segregation with the need to reintegrate the individual back into the institutional population at the earliest appropriate time. This underscores the nature of administrative segregation as an interim measure to be used only when there is no reasonable alternative.

For an inmate with a mental health issue, the implications of placement in administrative segregation, and the considerations surrounding his or her release from segregation, add a further and important dimension to the case.

For this reason, and with due regard to the Jury recommendations, the Minister of Public Safety and Emergency Preparedness intends to propose a number of amendments to the section of the CCRR dealing with Administrative Segregation that relate specifically to offenders with mental health disorders who have been designated as acute or high need intermediate care cases. These include:

- the addition of a mental health professional as a permanent member of the Institutional Segregation Review Board;
- that offenders with mental health disorders who have been designated as acute or high need intermediate care cases can engage an advocate to assist them with the institutional segregation review process;
- the obligation for an added executive regional review of all cases of inmates with mental health disorders who have been designated as acute or high need intermediate care cases for the purpose of identifying any practical alternatives to administrative segregation; and,
- adding a new step in the segregation review process to provide for an external review of all cases of an offender with mental health disorders who have been designated as acute or high need intermediate care cases. This step will assess management plans and strategies to help minimize time spent in administrative segregation.

CSC will be proceeding to amend the Commissioner's Directives to reflect the intent of these regulatory amendments during the first quarter of 2015.

Self-Injurious Behaviour

Improving capacity to address mental health needs of federal offenders is a corporate priority. Mental health, including self-injury, is a priority focus for CSC's Research Branch. The branch has conducted numerous studies to support a better understanding of federal offenders, which helps inform the policies and practices used by CSC to manage an increasingly complex offender population.

A key element of professional practice in the delivery of mental health services is the importance of working as an interdisciplinary team member. CSC's mental health services are delivered within a holistic, collaborative framework that encompasses various intervention models including medical, psychological, social, spiritual, correctional, and recovery. CSC has made developing an organizational understanding of self-injurious behaviour a priority, and stepped up its efforts to strengthen its policies and tools, train front-line staff, and improve the quality of care and management of self-injurious and suicidal offenders.

The publication of Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour in July 2011 and all subsequent revisions, was the culmination of the many collaborative efforts that emerged following the death of Ashley Smith. CSC's policy on the interdisciplinary management of complex, high needs cases now ensures that self-injurious and suicidal offenders are managed clinically and not strictly through an operational lens. This means the least restrictive measures possible are used to treat offenders while emphasizing and acting to preserve life as the paramount consideration. For example, a mental health professional assigns the observation level of an inmate on a suicide/self-injury observation status based on a clinical assessment of risk. This policy also strengthens and clarifies the role for health professionals in the management and treatment of self-injurious behaviour following each incident of self-injury and an assessment of the offender's needs using the Critical Response and Incident Management Plan and, if necessary, an Interdisciplinary Management Plan as part of the response.

Furthermore, to ensure greater oversight and focus on the use of clinical observation cells in response to self-injury, CSC requires all treatment centres and women's institutions to report regionally and nationally on the prevalence and frequency of their use. This will allow for the identification of individual cases where there is an elevated use of clinical observation. Identified cases can then be followed more closely by NHQ, the RCMHC and the National Psychiatrist and support can be provided to the sites for developing intervention strategies for the reduction of time spent in observation.

CSC acknowledges that the use of restraint equipment in the management of self-injury should never be the primary intervention nor does it replace efforts to understand and address the causes of self-injurious behaviour. Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour provides direction on the application, monitoring and discontinuation in use of the Pinel Restraint System. The Institutional Head has the authority for the application and removal of the Pinel Restraint System in situations where an offender is engaged in self-injury. However, a mental health professional may authorize the use of the system in cases where the offender is not engaged in self-injury if it is part of the offender's treatment plan. An offender placed in the Pinel Restraint System is under constant observation during the entire time while in restraints.

The Situation Management Model used by CSC and referred to by the Jury has evolved since 2007 to ensure that a greater multi disciplinary approach is taken with high need complex cases. Preservation of life is the primary goal of any intervention and must be consistent with the principles of the Situation Management Model. Accordingly, a security bulletin was issued in May 2008 to clarify that any item used by an inmate to inflict or attempt to inflict self-harm requires an appropriate intervention by staff that is both safe and reasonable in order to seize/retrieve the item, considered contraband in accordance with the CCRA.

CSC's Correctional Operations and Programs Sector, in collaboration with Health Services and the Canadian Association of Chiefs of Police, will revisit the application of the Situation Management Model to medical emergencies, incidents of self-injurious behaviour, and offenders with mental health disorders in order to ensure its continued suitability. This review will be complete by March 2015.

Criminal Misconduct

In the event of any alleged criminal misconduct concerning an offender with a mental disorder, the relevant case specific factors will be shared by institutional authorities, usually the Security Intelligence Officer, with police investigators and Crown Attorney officials. Due regard will be paid to any issues surrounding the assessment of the offender's mental health at the time of the alleged criminal misconduct.

Family Contact

In the event an inmate is transferred at a distance from sources of family or other persons of support, the institutional head has the discretion and can provide for longer visits for family or support persons and access via telephone contact. Consideration will also be given by CSC to expanding the opportunities for contact with family and support persons through the use of modern technology, such as video communication. In addition, CSC will review the visiting policy with a view towards streamlining and facilitating the approval process so that family and support persons are not subjected to repeated application requirements at each institution. This review and accompanying policy amendments will be complete by March 2015.

Transfer

CSC is required by legislation to consider a variety of factors when placing an inmate in an institution. The CCRA (section 28) requires that CSC take all reasonable steps to ensure that the penitentiary in which inmates are confined is one that provides them with an environment that contains only the necessary restrictions, taking into account many factors including accessibility to the person's home community and family.

Since 2007, revisions to Commissioner's Directive 710-2: Transfer of Inmates now specify that an inmate on high or modified suicide watch will not be transferred to an institution other than a treatment facility, unless the attending mental health professional determines the transfer would help to reduce the risk to the offender.

In addition, changes were made to ensure that the inmate's state of health and health care needs, as identified by a health care professional, are considered in all decisions relating to transfers, and that this information is documented in every inmate's final transfer decision. CSC also plans to further amend this policy to avoid transfers on Fridays or holidays – with the exception of emergency transfers. This will help ensure that appropriate resources are in place upon the arrival of a high need complex case at a receiving institution. This policy amendment will be complete by March 2015.

Information Sharing

The Jury recommendations illustrate concerns about not sharing valuable health information with staff and sources of collateral support.

Other than in limited circumstances, the law dictates that personal health information cannot be used or disclosed without an offender's informed consent. The sharing of personal health information must be consistent with the purpose for which the information was originally collected and only shared with those who have a need to know.

In order to provide clarification regarding what offender mental and physical health information (verbal, hard copy or electronic files) can be shared by health care professionals, when it can be shared, and with whom, CSC published the "*Guidelines for Sharing Personal Health Information*" in 2011. This document describes how information sharing can be carried out while protecting an individual's rights to privacy and confidentiality, and also ensuring that relevant parties have access to essential health information affecting management of an offender's case.

Staff Wellness

The jury expressed concerns about the impact on staff when dealing with cases of a difficult nature. CSC maintains a very active Employee Assistance Program (EAP) and Critical Incident Stress Management (CISM) programs that contribute to the overall promotion of workforce wellbeing.

CSC has also dedicated a staff resource to work with stakeholders, including management, employees and union representatives, to assess the need to develop a consolidated mental health strategy to further support its employees. The results of the assessment and proposed strategy will be considered by CSC's senior management by March 2015.

4. Sound Intervention

4.1 Jury Recommendations (4, 5, 6, 7, 8, 13, 15-21, 24, 48, 49, 96)

4.2 Background

The number of offenders with mental health needs continues to present significant challenges for CSC as it strives to improve its capacity to meet the growing need for mental health services in unison with its obligations as a public safety organization.

CSC is a very unique and dynamic work environment. Working with offenders with mental health needs can be among the most difficult and taxing challenges in the mental health profession. The recruitment and retention of qualified mental health professionals licensed by a regulatory body to provide services, as well as forging working partnerships with suitable mental health care providers in the external community are key elements in the provision of effective mental health services.

During 2013-14, nearly half of CSC's incarcerated population received at least one institutional mental health service, including 73% of the approximately 600 women in custody in federal institutions. Every day there are countless interventions made by staff – correctional, case management and health services, to help offenders with mental health needs cope with their confinement and to treat them with the dignity, support, compassion, and professional guidance that will make a positive difference in their lives and contribute to the safety of Canadians.

CSC's employees take pride in their work and the progress of their efforts. The tragedy and sadness of Ashley Smith's death was felt deeply by staff in CSC and instilled in them a strong determination to learn from the experience and to support CSC's efforts to move forward with the necessary changes.

The competency, professionalism and availability of a qualified and well trained staff are key factors for the success of CSC's Mental Health Strategy.

Several recommendations were made by the Coroner's Jury about mental health interventions, including the need for offenders with serious mental health concerns to be housed in therapeutic environments, the implementation of comprehensive and effective treatment strategies developed by interdisciplinary teams, and the need for community partnerships.

4.3 Actions

Improving CSC's capacity to address the mental health needs of offenders is one of CSC's corporate priorities. Over the past decade, significant advancements have been made in the provision of mental health services within CSC, including the implementation of CSC's Mental Health Strategy that includes five key components:

- Mental health screening at intake;
- Primary mental health care in institutions;
- Intermediate mental health care to address the needs of offenders that cannot be accommodated through primary care in regular institutional settings, but whose mental health problems are not so severe as to require inpatient psychiatric care in a Regional Treatment Centre (currently being piloted in two men's facilities); and intermediate mental health care provided to women classified as minimum or medium security in Structured Living Environments (SLE) at the women's facilities;
- Intensive inpatient psychiatric care at the Regional Treatment Centres; and,
- Transitional care for release to the community.

The Mental Health Strategy is founded on five key principles:

- Offenders are the central partner in their interdisciplinary team and collaborate with staff to develop and monitor their individual treatment plans;
- Mental health services are delivered within a holistic framework, which merges different intervention models including medical, psychological, social, spiritual, correctional and recovery;
- Mental health services respond to the diverse backgrounds and needs of offenders, with particular emphasis on women and Aboriginal offenders;
- Information sharing that respects policy and legislative requirements is required to support an integrated continuum of mental health services;
- There is a shared responsibility among all invested partners (e.g. CSC, community agencies, etc.) to support an integrated continuum of care for offenders with mental disorders throughout their sentence, and post Warrant Expiry.

Interdisciplinary Mental Health Teams (IMHTs) are responsible for identifying needs and service requirements, prioritizing mental health services, and monitoring and documenting clinical progress, in keeping with professional standards. IMHTs have been enhanced in CSC's institutions, including Treatment Centres, to coordinate the provision of mental health services to all offenders. The interdisciplinary mix of IMHTs includes psychologists, mental health nurses, clinical social workers, occupational therapists, behavioural science technicians, and psychiatrists. IMHTs collaborate with other institutional staff to provide a holistic and coordinated approach for offenders with mental disorders, including parole officers, primary workers, correctional managers, Elders, and other staff, as required. Within this holistic framework, an offender's criminogenic needs (e.g., violence, substance use) are addressed through correctional programming and are complimentary to mental health interventions.

A spectrum of mental health interventions are offered to offenders, including group and individual interventions in the areas of mental health promotion, prevention and early intervention, assessment and individualized treatment planning, and evidence-based treatment and support services in a manner respectful of gender and diversity. IMHTs also consult with and advise other institutional sectors regarding effective practices and strategies in the management of the mental health needs of offenders.

Interventions provided by the IMHTs are guided by mental health assessments, which are conducted over the course of an offender's sentence as required. These assessments may address diagnosis of mental disorders; cognitive functioning; the offender's ability to adapt in the institution or live successfully in the community; risk factors for criminal behaviour, or other relevant issues. Mental health professionals then identify treatment targets consistent with offender needs, based upon relevant assessments. Treatment plans and approaches are then developed in an individualized manner by the mental health professionals working with the offender. All clinical interventions are individualized to meet offender needs, respecting gender, age, culture and developmental needs and are authorized by mental health staff.

As is standard practice in the community, treatment intensity and the type of service provided or made available to an offender is based on identified need. This spans the range from 24 hour hospital/medical care and 24 hour psychiatric care for offenders with acute needs to ambulatory health care services during the day/evening and access to after-hours services (e.g., emergency access to outside hospitals). Offenders who are assessed as requiring 24 hour a day, 7 days a week services receive those services.

The overall goal of mental health services for male and female offenders is to provide coordinated and comprehensive mental health care to offenders with a variety of mental health needs in order to promote their well-being and successful reintegration.

Mental Health Service Delivery Model

CSC's current mental health service delivery model has evolved since 2007 and includes capacity to provide some services at all levels on the continuum of care (inpatient psychiatric hospital care in Treatment Centres, intermediate mental health care and primary mental health care) for both male and female offenders. However, challenges do exist in CSC's ability to fully implement the continuum of care.

For male offenders, CSC currently has primary care capacity and sufficient capacity at the psychiatric hospital level, but limited capacity to provide intermediate mental health services. For women offenders, regional inpatient capacity as well as intermediate mental health care for those classified as maximum security, remain areas that require improvement.

Inpatient psychiatric care is currently provided to male offenders with the most serious mental health needs at CSC's Regional Treatment Centres (RTCs) in each of CSC's five regions. RTCs are accredited and have designated inpatient psychiatric hospital beds to provide interdisciplinary treatment to offenders with mental and physical health care needs in safe and supportive environments. Each treatment centre offers acute and sub-acute mental health care as well as longer term psychiatric rehabilitation to offenders with the most serious mental health conditions and who require treatment.

For women offenders with acute mental health needs, CSC currently has 32 inpatient psychiatric care beds: 20 beds at CSC's Regional Psychiatric Centre (RPC) in Saskatoon, Saskatchewan, and 12 beds at L'Institut Philippe-Pinel de Montreal (a provincial psychiatric facility in Quebec). In addition, CSC has access to 2 beds at the Brockville Mental Health Centre in Ontario (following a recently signed five-year Memorandum of Understanding) and is continuing to negotiate with the Capital District Health Authority in Nova Scotia to provide accommodation and services to women with complex mental health needs at the East Coast Forensic Hospital on a fee for service basis.

CSC currently has limited capacity to provide intermediate mental health care for male offenders. Pilot units for intermediate mental health care of male offenders have been implemented in the Ontario and Atlantic regions. A Management Review of the Intermediate Mental Health Care Unit model highlighted the success of the initiative and supported the importance of continued implementation of intermediate mental health care, provided additional funding is made available.

Structured Living Environments (SLEs) have been established and further expanded since 2007, at each of the women's regional facilities in order to deliver intermediate-level mental health care and address the mental health needs of women offenders classified as minimum and medium security. These units provide a more intense level of mental health services than what is available through primary care. Dialectical Behaviour Therapy (DBT), which has been demonstrated to be an effective intervention for certain mental disorders, has been implemented in these units.

The SLE units accommodate inmates who are voluntarily admitted and treatment is provided by an Institutional Mental Health Team that cultivates a safe and secure environment through ongoing interaction. As the inmates have minimum or medium security classifications, they have access to the rest of the institutional facility, activities and programs.

With the implementation of CSC's Mental Health Strategy, primary mental health services in CSC have been enhanced and are better integrated within the wider correctional planning and institutional supervision frameworks, being mindful of the multiple needs presented by offenders with mental disorders (e.g. health, employment, substance abuse, education, programming, etc.).

Transitional care leading up to and following release to the community are essential for successful reintegration. CSC currently has mental health staff to support offenders with mental health concerns by preparing clinical discharge plans to promote continuity of services and to better prepare offenders with serious mental disorders for release to the community. Upon release, community mental health specialists at selected community sites are available to provide specialized support to address the particular needs of offenders with serious mental health concerns, including direct service provision (e.g. crisis intervention and counseling), linkage with community agencies, and coordination and support (e.g. accompaniment support, assistance completing forms and applications). Prior to an offender reaching warrant expiry, CSC staff work to establish linkages with provincial or territorial health services and community agencies to

facilitate a smooth transition for offenders with serious mental health concerns. Effective information sharing and collaboration with community health care services is critical to support the reintegration of offenders.

Partnerships in Mental Health

Consistent with the Jury's recommendations, the Government concurs that partnerships play a key role in providing effective mental health interventions and are a necessary addition to CSC's internal interventions. CSC currently has several partnerships in place with external mental health experts, including the following:

- The University of Saskatchewan, which facilitates, promotes, and assists in research in psychiatry and other related fields, as well as psychiatry internships to support CSC's recruitment efforts;
- The Centre for Addiction and Mental Health (CAMH) to develop revised training material for Dialectical Behaviour Therapy (including assistance with delivery and case consultations) and provision of consultation regarding the realignment of CSC's continuum of care;
- The Royal Ottawa Healthcare Group (ROHCG) for the delivery of a two day Mental Health Status Assessment Training for nurses who work at CSC reception centres. CSC has also entered into an agreement with the ROHCG for the provision of inpatient psychiatric services for women offenders at the Brockville Mental Health Centre;
- The Ministère de la santé et des services sociaux du Québec, which provides specialized psychiatric and forensic services in both official languages at the Institut Philippe-Pinel de Montreal. This facility offers twelve beds for women offenders and three beds for male offenders.
- Engagement with Canadian Institutes of Health Research on a national agenda on research in mental health and criminal justice to bring together legal, forensic mental health and general mental health stakeholders and identify research priorities and actions to further study mental health and criminal justice issues.

As part of helping to inform a response to the Jury recommendations, Public Safety and CSC sponsored a forum for representatives from the criminal justice and mental health stakeholder community in October 2014 to receive feedback on issues concerning reintegration planning for offenders with mental health needs, including the challenges of treating offenders diagnosed with borderline personality disorder.

CSC will continue to look at new avenues for developing partnerships with external mental health experts.

Looking Ahead

CSC is implementing a plan to have capacity at all levels of the continuum of care (inpatient psychiatric hospital care, intermediate care, primary care) for both male and female offenders to ensure that offenders receive mental health services at the level most appropriate to their needs. Most notably, this includes solidifying partnerships with provincial forensic psychiatric hospitals for inpatient psychiatric care for the small number of women offenders with highly complex mental health needs. CSC is also implementing a plan to provide enhanced intermediate care in a therapeutic environment for maximum security women with highly complex mental health needs.

In addition to the many structured interventions used in CSC, other therapeutic techniques/interventions have been used to enhance the therapeutic environment in women's institutions including horticulture, pet and art therapy.

Inpatient Mental Health Care

The provision of mental health services within appropriate therapeutic environments emerged as a key theme in the inquest. Towards this end, CSC has negotiated partnerships with provincial health care facilities to provide treatment to a small number of inmates who chronically engage in self-injurious behaviour or display other serious and complex mental health needs, and who have not made clinical gains in response to interventions provided by CSC. Entering into partnerships with willing provincial hospitals that have the capacity to manage these high need cases augments CSC's ability to allow women with serious and complex mental health needs to receive psychiatric inpatient services nearer to their home communities, a factor that is particularly significant for female offenders.

Increasing inpatient care capacity within proximity to existing women's institutions may facilitate outpatient follow up care for women on discharge from the hospital to further enable safe reintegration. In addition, women inmates may be more likely to consent to treatment in a psychiatric facility that is close to community supports.

Intermediate Mental Health Care

The creation of intermediate mental health care capacity has also been identified as a mechanism by which CSC could address the need to provide more therapeutic environments for inmates identified with serious and complex mental health issues, and/or self-injurious behaviour, who may or may not have consented to treatment.

CSC has a plan to refine its mental health service delivery model to more closely reflect an optimal mix of mental health services across the continuum of care (inpatient psychiatric hospital care in Treatment Centres; intermediate care in Treatment Centres and selected mainstream institutions; and primary care in mainstream institutions) based on the World Health Organization (WHO) optimal mix of service model. This will allow CSC to move towards implementing the full continuum of care as outlined in CSC's Mental Health

Strategy by augmenting intermediate mental health care within existing resources. Targeting the appropriate service and intensity level to individual offenders is aimed at efficient and effective service delivery.

An optimal model of care can be conceptualized as a pyramid of mental health services. Within this model, the majority of mental health care is self-managed or managed by informal mental health services (within CSC, this would be characterized by peer support, Elder support, chaplaincy, etc.). For individuals requiring additional support and clinical expertise, a more formalized service framework consisting of the following is required:

1. Primary care;
2. Intermediate care; and,
3. Specialist inpatient mental health services (within CSC this would equate to inpatient psychiatric care within Treatment Centres or with external service providers under contract for inpatient care).

Moving along the continuum from least to most intensive, fewer offenders are identified as requiring each level of care.

In order to increase CSC's capacity to provide intermediate mental health care, as a preliminary step, some existing hospital bed spaces within Treatment Centres will be repurposed to intermediate mental health care beds to meet the mental health care needs of those inmates whose mental health problems are not so severe as to require inpatient care in a psychiatric facility but who still require intensive services and access to 24-hour care.

One advantage of expanding intermediate care is that it allows a subpopulation of offenders with mental health issues and/or self-injurious behaviour who are not consenting, and/or who withdraw consent to treatment, to remain in a therapeutic environment for the purpose of allowing health care professionals to work to re-engage them into treatment. As intermediate mental health care beds are not designated hospital beds under provincial law, consent is not required for placement. Accordingly, offenders can be penitentiary placed to intermediate mental health care beds and offenders will no longer have to be transferred from Treatment Centres should they withdraw consent, but instead can remain within an appropriate health care environment. Consent to treatment, as opposed to placement, is always required.

As noted earlier, CSC currently has intermediate mental health care capacity for women offenders classified to minimum and medium security through the SLEs. Women inmates classified as maximum security require a commensurate level of care as is available to minimum and medium security inmates through the SLEs. However, the availability of intermediate mental health care for women offenders classified to maximum security is currently an organizational gap. This subgroup of maximum security women includes women who may have incompatibilities with other patients, significant Personality Disorders or co-morbid diagnoses, and represent a population management challenge for the organization. Accordingly, CSC will be making available intermediate mental health care services by repurposing some existing hospital bed spaces within the women's unit at the Regional Psychiatric Centre in Saskatchewan to intermediate mental health care beds which will be available for women classified as maximum security.

Ambulatory Mental Health Care

Moving forward, ambulatory resources will be made available to enhance CSC's ability to work with offenders with the most challenging mental health needs within institutions beginning April 2015. Women offenders account for approximately one half of the most challenging complex cases within CSC. To facilitate effective treatment planning, case consultations will be conducted by CSC's Senior Psychiatrist and/or external experts for offenders with the most complex mental health needs.

Institutional mental health teams will have access to internal and external experts to support ambulatory care during treatment and implementation of the case consultation recommendations. Experts (both internal and external) will include a diverse mix of skills and will be called upon, as needed, depending on the type of complex case and treatment need. Team members will be interdisciplinary and be an appropriate mix that can include psychiatrists, psychologists, social workers, occupational therapists, and mental health nurses. All five women's institutions have been funded with a social worker position to support the multi disciplinary mental health teams and coordinate with available community mental health services.

Aligned with the feedback from the October 2014 forum involving representatives from the criminal justice and mental health stakeholder community and building upon CSC plans for moving forward with enhanced ambulatory care, funds will be made available to secure temporary ambulatory contract/casual/term resources. These time-limited mental health resources will facilitate the delivery of specific mental health services tied to a patient's treatment plan while in custody and during transition to the community and safe release.

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) was implemented in CSC in 2001. It is a broad based, cognitive behavioral treatment, originally developed to treat chronically suicidal and self-injuring individuals. Over time, its scope has expanded and DBT is also used with individuals who exhibit a broad range of severe emotional and behavioral dysfunction. DBT is a principle driven approach that includes specific protocols. It consists of 4 components: individual therapy sessions, skills training, consultation team meetings and on-going coaching. Research findings show that DBT is effective in improving institutional functioning, mental health symptoms, interpersonal functioning, emotion regulation, coping, and self-control.

Peer Support

The concept of developing a Peer Support Team (PST) in women's institutions has its roots in observations by staff members of an informal peer support network among the women inmates at the Prison for Women in Kingston, Ontario. The initial program was conceived in 1990 and formally developed in 1996. Implementation occurred at the five regional facilities for women as they opened across the country between 1995 and 2004.

This program was originally designed to provide a small group of women with information on relevant topics to offer non-judgmental support and information to other women inmates, and to help with problem-solving and referrals to specialized resources. Topics included grief and loss, violence in women's lives, nightmares and flashbacks, eating disorders as well as self care, listening and interpersonal skill development. PST members were not trained as therapists or counsellors and the intent was never to provide therapeutic intervention during incidents of self-injurious or suicidal behaviour.

Participation in the Peer Support Program continues to be voluntary and open to all women inmates. Evaluations of this program were conducted in the late 1990's receiving positive results and support from staff members and women offenders. The evaluations also showed an additional benefit of increased self awareness and enhanced self esteem in women who participated in the program.

The program, guidelines and materials were revised and updated in 2002 by a National Steering Committee comprised of staff members and volunteers. Today, a Peer Support Team is in place at each of CSC's five regional women's facilities.

Following a Jury recommendation on this subject, a National Working Group was established in April 2014, to revitalize this program. This working group includes representatives from each women's institution as well as the Mental Health and Public Health branches of Health Services, the Aboriginal Initiatives Directorate and the Women Offender Sector. Consultations are underway with operational staff, women offenders, contractors and volunteers to identify best practices, opportunities, gaps and challenges. Consultations have also explored and highlighted the challenges in managing women offenders with complex mental health needs. Crisis situations require a full complement of interventions provided by highly skilled and trained mental health professionals while ensuring the safety and security of staff and inmates.

5. On Going Training and Development

5.1 Jury Recommendations (1, 2, 4c, 11, 66, 67, 80, 81, 82, 85, 88, 89, 90, 91, 92, 97, 98)

5.2 Background

Every CSC employee has a critical role to play in achieving the Service's mission and mandate. This includes not only the maintenance of essential training programs, but the continual professional development of staff knowledge and skills to improve both individual and organizational performance. Ensuring that staff members are properly selected and trained, and are given appropriate career development opportunities, is one of the nine principles of the CCRA, which are in place to guide CSC in achieving its main purpose - the protection of society.

CSC employs approximately 18,000 staff members. 85% of these employees work in institutions and community operations.

The largest group is the correctional officer (CX) group. In 2014, CX staff represented about 44% of CSC's workforce, or 7,677 employees. Another 15% of CSC staff is from the Welfare Programmes (WP) group, consisting of 2,776 employees who work mainly as parole officers and program delivery staff in institutions and community parole offices.

CSC employs nearly 1,250 health services staff, including nurses, psychologists, psychiatrists, social workers, and occupational therapists as well as a variety of health professionals under contract.

Nurses (NU) and psychologists (PS) at CSC form a core part of the health services staff. The number of nurses increased mainly between 2008 and 2009, following the implementation of the Health Services Recruitment and Retention Strategy in 2007-2008. Part of that strategy resulted in nurses being hired for the delivery of primary mental health care in institutions, as well as contracts obtained to deliver specialized services for offenders with mental health disorders. By the end of December 2013, CSC nurses represented 34% of the total NU employment in the federal public service, the highest percentage in federal government.

The psychology (PS) group in CSC represented 71% of the PS employees in the federal public service. The PS group grew by 9.3% from 2005 to 2014, or from 273 to 293 employees. As policies have evolved, so has the emphasis of these employees to provide comprehensive mental health assessments and more focused clinical interventions.

In December 2007, the report, *"A Roadmap to Strengthening Public Safety"* was released by an external Review Panel. This panel was formed by the Minister of Public Safety to examine all elements of the federal corrections system in Canada. It provided observations and made several recommendations on offender assessment and correctional programs and interventions. Furthermore, the panel noted that staff knowledge and skills should be aligned with a multi-disciplinary team approach to meet the needs of the rapidly changing offender population, including the increased numbers of those reporting mental disorders.

Many who live with mental illness claim that the stigma and discrimination they experience is more difficult to live with than the illness itself. As a result, it is believed that many do not seek treatment and instead try to cope on their own. Stigmatization also has a profound impact on offenders – already stigmatized by their criminal behaviour, and their mental health condition can result in further stigmatization within a penitentiary environment. Others are trying to come to grips with their mental health problems or being diagnosed with a mental health disorder for the first time while in CSC's care. The importance of dealing with stigma is therefore an essential element to the success of CSC's Mental Health Strategy. Staff awareness and understanding are key factors in the multi-disciplinary team approach behind the strategy.

A number of recommendations made by the Jury focus on improved learning opportunities and training for front line staff, management, and regional and national staff in several knowledge and skill areas, including ethics, the fundamentals of mental health and self-injurious behaviour, trauma-informed care, restraint minimization and de-escalation techniques as well as general medical procedures (first Aid CPR, medical distress and related interventions).

5.3 Actions

Like many other government organizations, CSC has modernized training delivery over recent years. Use of learning technology has been expanded and training has become more competency-based. Staff members are acquiring knowledge via on-line portals and then brought into a classroom setting to apply that knowledge and ensure it is well understood, practiced, integrated and transferred to CSC's operational realities. Research plays an important role in the curriculum that is developed to support learning programs in CSC. To ensure that staff members remain informed about research in CSC, they have access to all of CSC's research publications on the CSC website to augment learning activities. Use of on-line learning technology facilitates improved refinement to learning material and more consistent dissemination as well as ease of access and availability to staff, many of whom work shifts on a 24 hour a day, 7 day a week basis.

National Training Standards

CSC has established National Training Standards (NTS) that are mandatory for designated staff. The NTS represent fundamental learning and development requirements needed by employees to perform key aspects of their roles and responsibilities. These standards reflect the basic level of training that employees will receive according to the nature of their positions. Many of these standards include the requirement for refresher training at prescribed intervals.

As CSC training continues to evolve and targets specialized competencies, the number of standards has more than doubled in the last ten years. The standards are grouped under a number of key areas that are applicable to several occupations including orientation training, security, interventions, intervention for women offenders, and management development.

Since 2007, CSC has expanded training in a number of areas that relate to the Jury recommendations. For example, the Fundamentals of Mental Health (FMHT) is a two-day training program designed to enhance knowledge and understanding of various mental health issues and to clarify the role of staff interacting with and assisting offenders with mental disorders.

FMHT is now included in the orientation training for newly hired correctional officers. It is mandatory training for all existing correctional officers, primary workers and older sisters in women's institutions and treatment centres as well as correctional officers in maximum and medium security institutions. Also, the FMHT has been approved as an NTS for all parole officers working in institutions and the community. Since 2007, 10,800 staff members have received FMHT.

CSC has had suicide prevention training since the 1980's, and Suicide and Self-Injury Intervention training (Initial and Refresher Training) has been part of CSC's NTS since April 2005. The initial training is delivered to all staff through one of CSC's staff induction training programs: the Correctional Training Program (CTP – for correctional officers), the Parole Officer Induction Training (POIT) and the New Employee Orientation Program (NEOP). The CTP and POIT suicide and self-injury training includes online material, in-class knowledge transfer and application to concrete, in-person scenarios. The Suicide and Self-Injury Prevention Refresher training targets all staff that have regular interaction with offenders. The curriculum has recently been revised to include an on-line training module that is completed each year, and an in-class, scenario-based session that is delivered every two years by a mental health professional to enhance practical skills. Master trainers for the in-class portion have been provided with enhanced training in self-injury by an external expert. In 2013-2014, a total of 11,979 staff received the Suicide and Self-Injury Intervention Refresher Training.

First Aid and CPR has been part of NTS since 2003. Completion of this training ensures that individuals are able to demonstrate Basic (Emergency) or Standard First Aid skills as per the Canada Occupational Health and Safety Regulations, Part XVI – First Aid, along with Cardiopulmonary Resuscitation (CPR) level C, which now includes Automated External Defibrillator (AED) certification.

All correctional officers, primary workers, and correctional managers at medium, maximum, and multi-level institutions are designated as First Aid Attendants and require Standard First Aid and CPR level C including AED. The requirements for non-institutional workplaces, including District Offices, and administrative buildings such as Regional and National Headquarters are dependent on ambulance response times. At least one First Aid Attendant per 50 employees is available at all times when there are two or more employees at a given location. Certification is valid for a maximum of three years and refresher training for all designated staff is delivered accordingly.

Age and Gender Training Considerations

All primary workers, older sisters and behavioural counsellors at women offender institutions receive the 10-day Women-Centred Training (WCT) Orientation program. This program is highly trauma-informed, and focuses on an understanding of women offender issues and the ability to set boundaries, mediate and problem-solve, and to recognize the right balance between empowerment and the safe and secure reintegration of women offenders. All other staff who have ongoing contact with women offenders receive a three day abridged version of the program.

Candidates who apply for front line positions as primary workers older sisters participate in a selection process that ensures they meet the essential qualifications outlined in the Statement of Merit Criteria for the position which assesses the knowledge, skills and abilities, as well as an understanding and sensitivity of the needs of women offenders.

All of CSC's correctional programs delivered to women offenders are trauma-informed and women-centered.

Younger offenders represent a comparatively small proportion of CSC's population and it has been argued that they may differ from their older counterparts in important ways. To examine the situation, CSC's Research Branch reviewed the risk and needs presented by younger offenders in CSC's population earlier this year (523 offenders aged 18 to 21 years) and compared the results to older offenders (age 22 to 25 and 26 to 30 years). The results indicate that age is generally unrelated to most indicators of risk and need.

It is important to note, however, that CSC's correctional planning process, including needs identification and plan development, is highly individualized and that demographic information relating to factors such as age, gender and culture are a key part of developing correctional plans and informing an offender's overall program strategy.

Dialectical Behaviour Therapy Training

As discussed elsewhere, Dialectical Behavior Therapy (DBT) is a broad-based cognitive behavioural treatment, originally developed to treat chronically suicidal and self-injuring individuals, and implemented at CSC in 2001. DBT consists of four components: individual therapy sessions, skills training, consultation team meetings and on-going coaching.

In 2011, the existing training model was reviewed. This resulted in collaboration with DBT experts from the Centre for Addiction and Mental Health (CAMH), who developed a new DBT training model for CSC that was implemented in 2013. Based on this new model, the level of training received by staff who work with women offenders is matched with their level of involvement in the offender's treatment. For instance, licensed clinicians receive training in all four components, whereas correctional officers receive training in the on-going coaching component.

In addition to the four training modules, the CSC DBT model also incorporates a number of refresher trainings, to ensure continual learning. In collaboration with CAMH experts, each DBT institutional team receives monthly consultations and all CSC DBT clinicians take part in biweekly national consultations. National clinical rounds also take place for all institutional DBT teams every three months.

De-escalation, defusing volatile situations, communication skills training and conflict management skills training are currently embedded within many of CSC's learning programs including the Correctional Training Program, Women-Centred Training, Institutional Emergency Response Team and Crisis Negotiation Training.

Pinel Restraint System Training

The Pinel Restraint System is the only restraint system used for self-injurious behaviour in maximum and medium security institutions, women's institutions, and Regional Treatment Centres, as well as some community based inpatient psychiatric treatment facilities. Use of the system is detailed in Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour.

The CCRA s.4(c) requires that CSC only use measures that are consistent with the protection of society, staff members and offenders, and that are limited only to what is necessary and proportionate to the purpose of the Act.

CSC policy requires clinical reviews for offenders placed in restraints for a prolonged period of time, with a focus on developing an intervention strategy to reduce and eliminate the use of restraints.

Training in the application of this system is a key element in its use. Correctional officers (CX-01 and CX-02) working in Regional Treatment Centres, the Special Handling Unit (for men), all medium and maximum security Segregation Units, all primary workers at the women's institutions and all Emergency Response Team members at these institutions, receive the one-day program in the application of the restraints.

All nurses and correctional managers currently working in these institutions receive training, which includes the theoretical portion as well as an observation of the physical application of Pinel restraints.

Interdisciplinary Training

Effective interdisciplinary team work starts with strong interdisciplinary leadership. In order to support key managers/supervisors in fostering an interdisciplinary approach in the Regional Treatment Centres, a 1 day training workshop was delivered in Fiscal Year 2013-14 to share best practices on leading interdisciplinary teams (IDTs). The workshop engaged managers in various activities and exercises designed to provide staff with the skills and tools necessary in order to lead and support an IDT approach. Workshops were led by community experts. National consistency was achieved by setting the learning objectives nationally and through the development and use of an interdisciplinary reference toolkit.

Nursing and Training

Nurses at CSC are licensed professionals registered within their respective province or territory and association. Upon their hiring, nurses at CSC must have valid CPR/AED certification and are re-certified annually. Within six months of appointment, nurses complete the International Trauma Life Support courses, and undergo re-certification every three years. Nurses must also successfully complete the Emergency Medical Directive online training, which is based on the Emergency Medical Directives.

In March 2009, the Skills Enhancement Training for CSC nurses was launched. The main goal of this training program is to enhance the knowledge and practice of CSC nurses. CSC is currently in the process of reviewing this training initiative to focus on specific topics based on the nursing group's identified training needs.

The Nurse Orientation Program in place at CSC since 1997 was revised in 2010 to ensure that new nurses learn about CSC's practices, policies, directives, and guidelines in order to improve their confidence and abilities to work as a nurse in a correctional environment. Health Services is currently collaborating with CSC's Learning and Development Branch to revise the program and new learning technology is being used for participants to complete online, scenario based, self-directed learning activities, including WebEx sessions with a national facilitator. The training compliments onsite mentorship provided to newly hired nurses by the Chief of Health Services and experienced colleagues.

In 2013, Health Services partnered with the Royal Ottawa Hospital Care Group to develop and deliver Mental Health Status Assessment training to CSC nurses working in Reception Units as a component of CSC's Intake Health Status Assessment. This training is now being offered to non-intake nurses within CSC institutions.

Continuous learning is a key element of maintaining the professional practice of nurses and they participate in learning opportunities to improve their knowledge and skills in the provision of health care on an ongoing basis.

Management Development

CSC offers an Assistant Warden and Deputy Warden Orientation Program to recently appointed incumbents, which provides them with the required tools and knowledge to improve their understanding and application of managerial tasks, as well as ethical dilemmas and challenges encountered in managing an institutional environment. This training is offered within 12 months following appointment as an Assistant Warden or Deputy Warden and is also delivered to candidates in a pool for a position in the target group, or those who have accepted a long-term acting assignment.

In addition, newly appointed Correctional Managers at CSC are required to take the Correctional Manager Training Program. This training equips Correctional Managers with the necessary tools and essential knowledge to assist them in fulfilling their roles in managing correctional operations and social reintegration in a safe, secure, humane and reasonable way, while respecting the rule of law and the values of CSC. This training is offered within the first 12 months of their appointment as Correctional Managers.

A training session on Personality Disorders Associated with Self-Injurious Behaviours and Suicide was provided in 2013 by an external expert. Regional and national senior management representing Health and Operations participated in the session. It was designed to increase CSC's leadership knowledge and understanding of the characteristics of personality disorders, including gaining insights into the behaviours and to explore strategies to improve the outcomes for these offenders. This forum also included a facilitated discussion on the practical applications of this information in the day-to-day management of this subpopulation and functioning of institutions.

Management Mentoring

Knowledge and experience are the most valuable elements managers can bring to the table. To take advantage of this wealth of expertise, CSC is implementing a national mentoring program to support and develop middle managers and supervisors throughout the organization. For example, the Middle Manager Mentoring Program (MMMP) is being developed to focus on the specific needs of supervisors and managers who are matched with mentors at a senior level. Over the course of a year, individuals will receive opportunities to learn through conversations, new perspectives, work activities and networking opportunities. The objective of this program is to forge a powerful relationship to preserve corporate memory, enhance ethical leadership and decision-making abilities, and better prepare future leaders for the challenges of tomorrow.

Furthermore, CSC has created a Management Development Portal (MDP) specifically for managers, but available to all CSC staff, to assist them in their day-to-day tasks. The MDP provides access to e-learning, videos, networking opportunities, training content and resources, guides, as well as a variety of information (e.g. on policies and legislation) to help middle managers and supervisors in their daily work, as well as to support their development and learning needs. Information and resources are organized by topics that speak to

the daily needs of middle managers and supervisors including mentoring, conflict resolution, performance management, leadership and engagement, and workplace wellness.

This initiative will be expanded to newly appointed Wardens and Deputy Wardens.

Ethics in CSC

Since 2007, CSC has delivered the Values-Based Leadership Program training to management teams in its institutions across Canada. Learning objectives include:

- to enhance values-based decision-making through a better understanding of the CSC Values Statement, its associated behaviours and leadership responsibilities;
- to develop practical responses to dilemmas and consider one's decisions and behaviours, as well as those of others;
- to discuss factors which will affect the ability to exert values-based leadership and personal ethical behaviour in the workplace; and,
- to develop strategies to mitigate factors that work against and strengthen factors that supports, the ability to exert values-based leadership and personal ethical behaviour in the workplace.

In response to CSC's 2012 Ethical Climate Survey, CSC's Office of Values and Ethics developed a practical guide, *Leading through Values,* designed to help managers and supervisors have values-based discussions with staff.

In addition, all employees at CSC are required to participate in a one-day Values and Ethics Workshop that involves the analysis of complex ethical issues they may face and identifying the courses of action for resolution.

Correctional managers and all other front-line managers receive a two-day Values Based Leadership Program and middle management and senior management receive the three-day Ethical Leadership Program.

All executives, including wardens, participate in the two-and-a-half-day Ethical Leadership in CSC program which includes the promotion and application of the new "*Leading through Values*" manager's tool kit.

Values and ethics training is also an integral part of all new employee training and orientation programs.

The establishment of a Correctional Service of Canada Ethics Committee is one element of CSC's ethics strategy. While the federal public service *Values and Ethics Code* does not mandate the creation of an ethics committee, authority for its establishment is contained within the general authority the Code gives to the Deputy Head to *"add compliance measures beyond those specified in this Code to reflect their department's specific responsibilities or the statutes governing its operations."*

CSC has a National Advisory Committee on Ethics (NACE), chaired by the Commissioner and composed of three independent, impartial and external ethics advisors, as well as several senior managers and union executives for the purpose of ensuring that ethical values are embedded throughout the organization. To achieve this purpose the Committee provides independent objective advice and considered opinion on ethical issues or concerns within the organization.

Case Study

The first of the Jury's 104 recommendations was for Ashley Smith's experience within the correctional system to be taught as a case study to all management and staff at the institutional, regional and national levels in CSC.

CSC will integrate a case study on Ashley Smith's experience within its current ethics related learning framework. The Service is assessing the learning needs and curriculum that will best offer a comprehensive understanding of the actions and gaps in this case. Learning material will be finalized prior to March 2015 and will include a case study package that is adapted to the learning needs of specific target groups.

6. Robust Governance and Oversight

6.1 Jury Recommendations (3, 10, 14, 22, 26, 36, 37, 43-45, 52, 73-79, 83, 93-95, 99, 102, 103)

6.2 Background

The mandate of the federal correctional system, as defined in law, is to contribute to the maintenance of a just, peaceful and safe society by carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders, and by assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.

CSC carries out its mandate by providing federal correctional services across the country from small and large urban centres to remote communities across the North. CSC manages institutions for men and women, mental health treatment centres, Aboriginal healing lodges, Community Correctional Centres (CCCs) and parole offices where offenders are supervised in their communities.

CSC is organized to provide effective correctional services in a fiscally responsible manner, at the national, regional, and local operations level, and all of CSC's daily activities and long-term goals are aimed at contributing to public safety in Canada.

CSC's National Headquarters provides support to the Commissioner and the Executive Committee (EXCOM), and delivers services to all of CSC in a number of key areas including policy and planning, program development, correctional operations support, research, health services, human resources and functional leadership on women offender and Aboriginal offender initiatives. Regional Headquartersprovide support to National Headquarters by monitoring the delivery of various programs and services and providing direction and supervision over local operations. Local operations consist of the institutions, CCCs and parole offices that carry out correctional activities.

The complex, diverse and evolving offender population creates multiple pressures and demands in CSC's operating environment. To fulfill its responsibilities, CSC has set six corporate priorities to guide its direction and ensure it successfully meets its challenges and obligations.

This includes the priority to improve capacities to address the mental health needs of offenders. To address this priority, CSC is continuing to strengthen the continuum of care for offenders with mental health needs.'

The Coroner's Jury expressed concern about the suitability of CSC's governance structure in a number of areas and made several recommendations to strengthen oversight, enhance independent review and access, realign the responsibilities for women's corrections, expand advocacy for inmates and to ensure that the Jury's verdict and recommendations received widespread attention in the public and internally at CSC.

6.3 Actions

The Government recognizes that a robust governance structure is necessary to support and continually improve the services provided to offenders as well as ensure that laws and policies are applied fairly and consistently. Strong governance and oversight tools also provide greater integration of all aspects of managing offenders, including correctional operations, reintegration, and physical health care and mental health care services.

CSC institutions have a management structure in place to ensure clear responsibilities and accountabilities. This management structure also promotes the continuous flow of information to staff on operational issues (including security incidents and intelligence), offender movement (including segregation admissions), staff deployment and the day-to-day activities of the case management process.

Every offender is assigned a Case Management Team which includes a parole officer and a correctional officer or primary worker. This team may also include ad hoc members such as a manager of assessment and intervention, a correctional manager, psychologist, behaviour counsellor, program officer or Aboriginal liaison officer. Each Case Management Team works with the offender to develop an individualized Correctional Plan and intervention strategy. The team also conducts ongoing monitoring, engages in case discussion, provides referrals to programs and specialized services, and undertakes comprehensive reviews and case preparation to support the decision making process in every offender's case.

When mental health concerns are identified, an offender's case is also overseen by an Interdisciplinary Mental Health Team, which is chaired by the chief psychologist, clinical manager or delegate, and with team members that may include mental health staff, health care staff, parole officers, correctional managers, Elders, and ad hoc members as required. The functions of the team include identifying needs and services required, prioritizing mental health services, and monitoring and documenting the clinical progress of individual offenders.

Oversight

CSC has a number of mechanisms that enable internal oversight of its correctional operations and health services, including Compliance and Operational Risk Reporting, Boards of Investigations, Mortality Reviews, an Evaluation function, and an Internal Audit Sector that provides independent and objective assurance services to improve CSC's operations and assist in ensuring compliance with legislation, policies and procedures.

The Correctional Investigator has a legislative mandate to "conduct investigations into the problems of offenders related to decisions, recommendations, acts or omissions of the Commissioner or any person under the control and management of, or performing services for or on behalf of, the Commissioner that affect offenders either individually or as a group"(Correctional and Conditional Release Act [CCRA], 1992, s.167). It is the role of the Correctional Investigator to offer independent opinions on CSC's decisions and actions.

As well, the Office of the Auditor General Canada regularly audits and provides recommendations relating to CSC's operations and programs. CSC will be cooperating with the Auditor General in future audits to monitor the implementation of this response.

Other external sources also provide oversight to CSC's activities, including its Citizen Advisory Committees (CACs), Departmental Audit Committee, many non-government organizations such as the Canadian Association of Elizabeth Fry Societies (CAEFS) and the John Howard Society, the Health Care Advisory Committee and Accreditation Canada.

In addition, Health Canada, through its participation on the Deputy Minister Steering Committee responding to the Coroner's Inquest touching the death of Ashley Smith, has committed to work collaboratively with CSC and other partners on reviewing activities connected with the delivery of mental health services in federal correctional facilities that serve women.

Health Services Governance

In September 2007, a new organizational structure was put in place to create the Health Services Sector and add a new Assistant Commissioner of Health Services (ACHS) position to CSC's Executive Committee. It established a single governance structure responsible for the delivery and quality of physical health services for offenders and to meet the following objectives:

- create one structure governing Health Services' resources and activities;
- strengthen the management of Health Services with a new Sector at National Headquarters that includes five regional directorates;
- provide a stronger voice for Health Services in CSC;
- implement comprehensive quality-improvement programs; and,
- create a new mental health governance structure to give Health Services a functional role in overseeing Regional Treatment Centre operations.

In response to a recommendation in the Office of the Correctional Investigator's report *A Preventable Death in Custody*, CSC further evaluated governance proposals for health service delivery, under the direction of an external consultant.

It was recognized that CSC could better maximize the use of its mental health resources to provide timely and effective interventions for offenders in need. It was determined that the wide variety of reporting relationships for mental health professionals in CSC was contributing to a lack of clarity regarding accountabilities, as well as to gaps or duplication between functions and roles.

EXCOM approved a further change to the organizational structure for mental health services at the regional and institutional levels as of April 2013. This resulted in a fundamental shift in reporting relationships for mental health staff in CSC institutions and the community. It brought mental health care providers in mainstream institutions and the community into a direct line reporting relationship with the Health Services Sector.

Furthermore, effective April 1 2014, a new governance model for Regional Treatment Centres was put in place, transferring responsibility of all health services from CSC's operational managers to the Health Services Sector. Given that Regional Treatment Centres function as specialized facilities that are considered both "penitentiaries" and "hospitals", operational-specific functions (e.g. security) continue to report to Wardens.

CSC has now created a health care system within the federal correctional environment. The new model is expected to result in quality services for offenders by:

- standardizing practices;
- integrating physical and mental health services;
- improving communication between physical and mental health care professionals;
- creating clear lines of accountability for clinical decisions;
- supporting an interdisciplinary approach in the provision of health care;
- facilitating horizontal collaboration between health and operations; and,
- improving the overall efficiency and effectiveness in delivering services.

Although CSC uses a strong multi-disciplinary and collaborative approach to offender management, these changes ensure that health care professionals are focussed on providing physical and mental health care to offenders and that security and operational staff members are engaged in institutional security, supervision and risk management priorities.

CSC has also enhanced its clinically-informed policy and operational decisions, including the creation of clinical leads at National Headquarters (senior medical advisor, public health medical advisor and senior psychiatrist) to help guide and advise management at all levels. As well, health governance has been improved with the creation of health committees and process structures, including the Essential Health Services Framework Committee, the Pharmacy and Therapeutics Committee, and Regional and National Complex Mental Health Committees. In addition, the increased use of interdisciplinary teams on the frontline, including a broader diversity of health staff, and the improved training of non-health staff (e.g. Fundamentals of Mental Health, Dialectical Behaviour Therapy, and interdisciplinary team training), has enabled the health governance structure to work more closely with operations colleagues.

A Health Services/Institutional Operations Forum has also been created to assist Health Services in sharing information on activities and priorities, supporting consistent planning and reporting, and discussing risks and opportunities related to health services in CSC institutions. Forum participants meet quarterly, and include senior executives from both health and operations.

The Health Services Sector is now uniquely situated in its reporting structure within CSC. The Health Sector works collaboratively with Institutional Operations to develop policies and guidelines for front line health and operations staff.

Ensuring the provision of Commissioner's Directives to contracted physicians is one example directly linked to a Jury recommendation in this context.

Incident Reporting

Since 2007, several changes regarding the documentation, reporting, and oversight of incidents involving self-injurious behaviours have been reflected in Commissioner's Directive CD 568-1: Reporting and Recording of Security Incidents.

For the purpose of incident reporting in OMS, self-injury is classified under security incidents, however CSC considers that chronic self-injury should be treated and managed first and foremost as a mental health concern.

The policy for the reporting of security incidents was modified to ensure consistency at all levels. Specifically, changes were made to clarify and streamline the reporting process to ensure national consistency and to ensure that National and Regional Headquarters were notified of incidents in a timely and comprehensive manner. In addition, procedures were rewritten and annexes were created to support the incident reporting process. This includes an Annex created to include all incident types and other key elements that must be well defined to ensure accurate reporting at the institutional and community levels. Furthermore, the changes clarified that any incident involving self-injurious behaviour must be specifically coded and conveyed accordingly.

Documenting Self-Injurious Incidents

For the documentation of self-injurious incidents, policy clearly directs all staff, volunteers and contractors to document an incident or behaviour that has been witnessed or observed in a Statement/Observation Report (SOR) in a detailed and concise matter. Staff members must provide a comprehensive statement clearly describing their observations or involvement in each security incident, including a description of the nature of any self-injurious behaviour and any corresponding change observed in the offender's physical appearance. SORs are completed by all staff members, including health care staff, while also ensuring that health practitioners provide comments regarding changes in the offender's physical well-being.

A morning meeting is required at every institution each working day to review operational concerns, including incidents over the last 24 hours (or weekend), and to provide specific direction for the day's operations. Security incidents, including self-injurious behaviours, the latest security intelligence entries, cases placed in segregation, human resource utilization and other non-routine activities are reviewed.

In addition, all incidents of self-injurious behaviour are reported through the daily situation report of security incidents (SITREP), which is disseminated to a large number of staff at the national, regional and institutional level. The SITREP is discussed at the National Headquarters weekday morning Operations meeting, at which various Sectors are present, including Correctional Operations (security) and Health Services.

Review of Self-Injurious Incidents

The Health Services Sectors routinely reviews Incident Reports and flags concerns to senior management as required. As discussed elsewhere, CSC has implemented Regional Complex Mental Health Committees (RCMHC) which are co-chaired by the Regional Director of Health Services and the Assistant Deputy Commissioner of Correctional Operations of each region, as well as a National Complex Mental Health Committee, which is chaired by the Director General of Mental Health.

In addition, in order to ensure greater oversight and focus on the use of restraint equipment in response to self-injury, CSC requires all treatment centres and women's institutions to report regionally and nationally on the prevalence and frequency of their use. This is similar to the performance reporting done in major forensic hospitals. This will allow for the identification of individual cases where offenders are placed in restraints repeatedly or for extended periods of time. Identified cases can then be followed more closely by NHQ, the RCMHC and the National Psychiatrist and support can be provided to the sites for developing intervention strategies for the reduction of time spent in restraints.

The expanded Regional Complex Mental Health Committees' operate as management committees meeting monthly to review all complex cases and incidents of self-injury, focusing on repeat self-injurious behaviour, flagging items of concern, and consulting/engaging with institutions to offer support and advice in the management and treatment of offenders with complex mental health needs, as required.

Questions related to the functioning of RCMHCs will be added to a Health Services Evaluation currently being conducted by CSC's Evaluation Branch. This will be accomplished by way of a staff questionnaire for institutional and regional personnel. This will provide useful information about the efficacy of the RCMHC, and identify opportunities for improvements.

Use of Force Review

In June 2014, a revised Use of Force Review module was added to the Offender Management System for use at five institutions across Canada, and by those responsible for Use of Force review at the regional level. The changes to the module resulted from an EXCOM decision and aim to increase efficiencies for the review of use of force incidents. These changes create a streamlined, triage process, including a clear explanation for review and decision-making. The module provides a more user-friendly structure to allow users to capture and distribute use of force related information for timely review, when required.

The revised OMS modules will be rolled out nationally in tandem with the updated Commissioners Directive 567-1: Use of Force. It is anticipated that this policy will be promulgated by January 2015.

Women Offender Governance

Today's operating philosophy in women's corrections has evolved over the past 20 years and been significantly influenced by *Creating Choices*, the Report of the Task Force on Federally Sentenced Women (1990). This task force was formed to develop a comprehensive strategy for women's corrections and included correctional practitioners and stakeholders from government agencies and non-governmental organizations with a direct interest in this field. Their report proposed an entirely new operating model for women's corrections that led to the closure of the Prison for Women and the opening of the regional facilities for women now in place.

The Women Offender Sector (WOS) was established at National Headquarters in 1995. In 1996, the Deputy Commissioner of Women (DCW) position was created to provide support and direction to staff who deliver women correction's activities in the regions.

The continued development of correctional interventions for women is still guided by the fundamental principles found in *Creating Choices:* empowerment; meaningful and responsible choices; respect and dignity; a supportive environment; and shared responsibility.

Several independent reviews have been undertaken since *Creating Choices*, notably the Report of the Commission of Inquiry into Certain Events at the Prison for Women (1996), which led to the creation of the DCW role; the Report of the Auditor General into the Reintegration of Women Offenders (2003); *Protecting Their Rights - A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women* by the Canadian Human Rights Commission (2003); and, *Moving Forward with Women's Corrections,* the Expert Committee Review of CSC's Ten-Year Status Report on Women's Corrections (2006). The findings and recommendations from these reviews have helped CSC develop the management policies, practices and interventions that still evolve for women offenders.

The independent panel report from 2007, *A Roadmap to Strengthening Public Safety*, also examined women's corrections by looking at the Expert Committee Review of CSC's Ten Year Status Report on Women's Corrections and endorsing CSC's response to their recommendations. In particular, the panel agreed that a "strong functional and strong leadership role by the Deputy Commissioner for Women, rather than a line authority model, is the most effective governance structure", and concurred with CSC's commitment to "enhance and strengthen the relationship of the DCW and her staff with all levels of the organization in order to ensure a clear and sharpened women-centered focus in support of the women's correctional model."

Following the Jury recommendations, CSC once again carefully examined this issue and concluded that a strong functional and leadership role by the DCW continues to be the most efficient and effective governance structure for women's corrections.

CSC will, however, remain vigilant in its continued review and assessment of women's corrections, and will strengthen the DCW's role and responsibilities where appropriate. These considerations include increased opportunities to educate CSC staff and stakeholders, implementing a separate human resource model for women offender institutions and women's supervision units, and a potential separate finance model where monies could be specifically set aside for women's initiatives. Additional performance related considerations include involving the DCW or Director General of Women Offenders in all selection processes for Wardens and Deputy Wardens at women's institutions, creating a formal mentoring program for Wardens of women's sites and parole officer supervisors in women supervision units, implementing routine conference calls with Wardens of women offender institutions, and developing a performance measurement framework for monitoring key activities and outcomes related to women offenders.

Advocacy

Several Jury recommendations were made regarding the implementation of an independent Rights Advisor and Inmate Advocate (RA-IA) for all inmates.

As previously mentioned, amendments will be proposed that will allow offenders with mental health disorders who have been designated as acute or high need intermediate care cases to engage an advocate to assist them with the institutional segregation review process.

It is believed that in light of the existing patient advocate role for mental health in the provinces and territories and the proposed provisions specified above, a specific rights advisor function would be redundant and conflict with the existing process in this respect. Provinces provide advocacy services for all patients being treated on an involuntary basis including federal offenders. CSC facilitates and encourages the involvement of these advocates, or their alternates and official representatives in its institutions and in its decision making processes.

In addition, as part of the Code of Ethics for Registered Nurses (Canadian Nurses Association, 2008 Centennial Edition), nurses have an advocacy responsibility for the use of the least restrictive measures or if they believe that the health of those persons in their care is being compromised by the decision-making of others.

Furthermore, offenders will continue to benefit from the support and representation provided by non-governmental agencies such as the John Howard Society, the Native Women's Association of Canada and CAEFS, as well as the Office of the Correctional Investigator, the CACs and other volunteers active in federal corrections. Typically, these organizations are provided unimpeded access to all CSC facilities unless there are circumstances that present a risk to the security of the institution or of any person.

Secure Unit interview rooms have been constructed at all women's institutions to facilitate meetings that are sensitive or personal in nature between women in a secure unit or a segregation facility and external representatives or CSC staff.

Offenders can also contact their legal representatives at all times and have direct telephone and written grievance access to CSC's Right's, Redress and Resolution Branch. This branch was established to promote respect for and the protection of individual rights through the application of legislation, restorative justice and redress mechanisms.

Every institution has an elected inmate committee that can also play a strong role in ensuring that the rights of every offender are respected. For example, when changes to a Commissioner's Directive are proposed, CSC consults with Inmate Committees on a routine basis at all of its institutions.

Citizen Advisory Committees

Citizen Advisory Committees (CACs) offer an independent community perspective by directly observing the operations of the federal correctional system. CACs have been established in law to provide a "public presence" in federal corrections and to observe, advise and liaise. Members meet with CSC staff, offenders, community groups and other citizens to advise on ways to improve CSC's facilities and programs.

CACs are represented at each of CSC's institutions and district parole offices across Canada. Members are ordinary citizens who come from different cultures and backgrounds and who believe in public safety, the right of all citizens to be involved in the correctional process, and the ability of offenders to become law-abiding citizens.

CACs are impartial observers of CSC's day-to-day operations. They help assess if offenders are getting adequate care, supervision, and services in accordance with the CCRA. CAC members visit facilities regularly to meet with offenders, and CSC officials and staff. They are often requested or may ask to observe crisis situations taking place at a CSC site. This provides CSC with an opportunity to demonstrate openness, transparency and accountability.

CACs provide an important link between communities and CSC. They listen to public concerns and offer CSC a community perspective on the impact of its policies, programs and services. They also help raise awareness of federal corrections and encourage citizens to get involved. CACs report annually on their progress.

Distribution of Coroner's Jury Verdict and Recommendations

CSC posted an electronic copy of the Jury's verdict and recommendations within a month following receipt of the final version, on the internal intranet site accessible to all staff, and on the CSC website, accessible to members of the public. In addition, a printed copy of the verdict and recommendations was posted at that time in an appropriate and prominent location in each of CSC's institutions and Treatment Centres for all staff to read.

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